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the Wisconsin Medical Journal

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the Wisconsin Medical Journal

ESTABLISHED 1903

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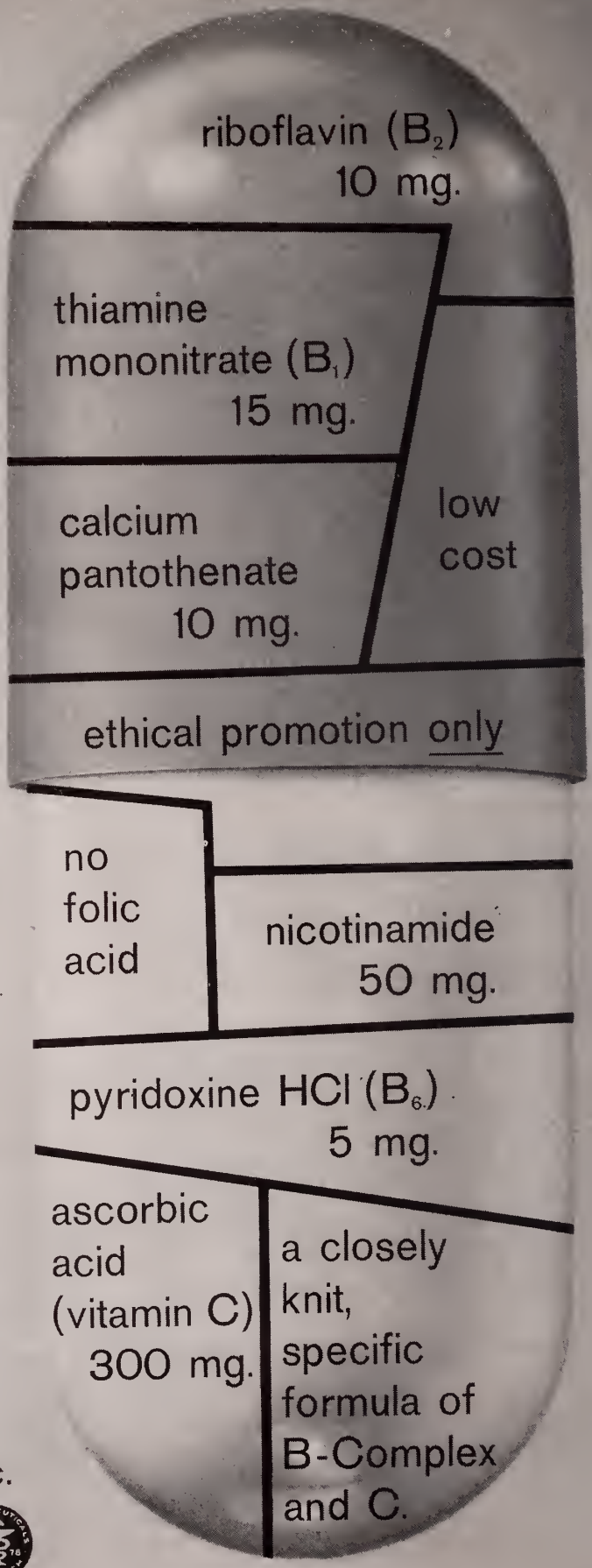

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Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS RECEIVED

THE GOLDEN AGE COOKBOOK

By Phyllis MacDonald. Doubleday & Co., Inc., Garden City, New York, 1961. 192 pages. Price: $2.95.

EMOTIONAL FACTORS IN PUBLIC HEALTH NURSING

A Casebook. Edited by Abraham B. Abramovitz, for the Wisconsin State Board of Health. University of Wisconsin Press, Madison, 1961. 171 pages. Price: $4.00.

HEREDITY IN OPHTHALMOLOGY

By Jules Francois, Professor of Ophthalmology, University of Ghent, Belgium. C. V. Mosby Co., St. Louis, Mo., 1961. 731 pages. Price: $23.00.

ABDOMINAL OPERATIONS

By Rodney Maingot, F.R.C.S., London. With special articles by 36 British and American contributors. 4th Ed. Appleton–Century–Crofts, Inc., New York, 1961. 1402 pages. Price: $29.50.

MEDICAL PHARMACOLOGY

Principles and Concepts. By Andres Goth, M.D., Professor and Chairman, Department of Pharmacology, University of Texas Southwestern Medical School. C. V. Mosby Co., Mo., 1961. 551 pages. Price: $11.00.

BOOK REVIEWS

BELOVED PROFESSOR

Life and times of William Dodge Frost, by Russell E. Frost. Vantage Press, New York, 1961. 350 pages. Price: $3.75.

The "Beloved Professor" is an interesting biography of William Dodge Frost, distinguished scientist, public-spirited citizen, and loved father and husband, written in affectionate regard and tender memories by his son, Russell E. Frost.

Doctor Frost was born September, 1867, in a period of intellectual development occasioned by the culmination of some and advances of other sciences contributing to the control of certain communicable diseases.

The author tells the story of his father's participation in furthering these sciences and about many other incidences which create the picture of his father in the framework of his time.

The story begins in Minnesota with the birth of William Frost in Lake City, some 30 miles south of Redwing. He lived there with his family until he was ten years old. At this period they moved in a covered wagon to the Western border of that state into a portion of the prairie that had been staked out by his father as a homestead which was in the vicinity of the small town, Marshall.

On this prairie he lived for the next ten years doing the chores of a farm boy and helping with developments in the growing community. The most significant thing was the family's and neighbors' interest in the education of their children. They were far away from the excitement going on in the European countries over the discovery of bacteria as the cause of certain dread diseases from epidemics of which mankind had been seeking safety through flight since the beginning of history. Communication with the other side of the world was a rare achievement. This young boy probably knew, or had heard, the word "bacteria" but he could have had no concept of the role of these organisms as the cause of disease.

Willie Frost became a pupil in the home of a neighbor woman who was teaching her own children. Soon a one-room school building was constructed by Willie's father with Willie's help. From this beginning he entered the high school in Marshall, and from there he went to the University of Minnesota where he secured a Bachelor of Science and, later, a Master of Science degree.

As a farm boy, young Frost became interested in the flora and fauna of the countryside, and when he was pursuing his education at the University of Minnesota made botany his chief subject. He graduated with a Bachelor of Science degree in 1892. The country was in the depth of a disastrous depression. He looked for a job as a teacher of science, particularly botany, but none was available. Finding no position, he returned to the University for another year and secured another degree, Master of Science.

Even with the additional education and training, jobs were hard to find but through a concatenation of circumstances he was brought under the influence of the Health Officer of the State of Minnesota, who was a well informed person and at the time was looking for a laboratory person to help him put into practice some of the new ideas concerning the science of bacteriology and disease control. He accepted a position with Doctor Hewitt. He knew little about the methods of applying these sciences. How-

ever, his industry, eagerness to learn, originality and initiative insured his progress along the road which brought him into a lifetime of study, research and teaching.

He came to the University of Wisconsin in October, 1895, on the invitation of Dr. H. L. Russell, the first professor of bacteriology in any university in this part of the country. Bacteriology, up until this time, was taught only in medical schools. Doctor Russell was interested in the control of diseases of men and animals. Under his tutelage young Frost advanced rapidly from assistant to assistant professor, and then full professor, securing along the way a degree of Doctor of Philosophy (Ph.D.) from the University of Wisconsin. Following this he took advantage of every occasion to become acquainted with other universities throughout the country and what they were doing and the men who were expanding scientific knowledge in these fields. Thus he became a student in Johns Hopkins University in Baltimore and later still in Harvard University in the Department of Preventive Medicine and Hygiene under the chairmanship of Dr. M. J. Roseneau. From this institution he received the degree of Doctor of Public Health (Dr. P.H.).

From this point the story of the life of Dr. William Dodge Frost as bacteriologist and an important figure in the new public health movement is told. For those unacquainted with this era and the men who took part in it, this book will be informative; for those acquainted with it, and with Doctor Frost and the University of Wisconsin in this period, it will recall many pleasant memories. The casual reader will enjoy the story—Beloved Professor.—WILLIAM D. STOVALL, M.D.

THE ROLE OF THE PHYSICIAN IN ENVIRONMENTAL PEDIATRICS

By Carl C. Fischer, M.D., Professor and Head of the Department of Pediatrics, Hahnemann Medical College and Hospital; Director of the Health Service, Girard College, Philadelphia, Pa. Landsberger Medical Books, Inc., 51 East 42nd St., New York, N. Y. 122 pages, Price: $5.50.

This small book (only 122 pages) is a compilation of talks given the medical students about sociopediatrics. It contains much practical information for most physicians but especially for pediatricians, public health physicians and general practitioners. Much of the material concerns the physician's relationship not only to the entire family but also to the community.

The author calls the problem the "social era" of pediatrics. The chapter on accident prevention is very good. The one on adoptions gives much sound information. The chapter on school health reflects the general feeling of public health workers that the private physician should do the periodical medical examinations, etc. Because of the increasing interest in the adolescent and also juvenile delinquents these chapters are quite worthwhile.

This small book is written in a rather informal but quite readable style and gives much food for thought.—MARGARET E. HATFIELD, M.D.

THE CONCISE ENCYCLOPEDIA OF MODERN SURGERY

By James Hale Rutledge, B.S., M.D., F.A.C.S. Chilton Co., Book Division, 56th and Chestnut sts., Philadelphia 39, Pa., 1960. 308 pages. Price $8.00.

A rather comprehensive review of modern surgery written for the patient.

Beginning with the division of medical practice into the various specialities, the realm of surgery is covered from surgeons, hospital and diagnostic procedures through pathology and anesthesia. A systemic review of the many facets of the modern field of surgery follows in an orderly manner.

This encyclopedia would be of value to the layman interested in reviewing the field of modern surgery and to the patient interested in a more detailed discussion of his problem. A number of the simplified drawings would be of value to the physician in the explanation of disease and surgical procedures. —ROBERT O. JOHNSON, M.D.

STRESS AND CELLULAR FUNCTION

By H. Laborit, M.D. Médecin en Chef de la Marine Francaise; Directeur de la Section de Recherches Physiobiologiques de la Marine Nationale Francaise; Chirurgien des Hôpitaux Maritimes; Membre Associé National de l'Académie de Chirurgie. Recipient of the Albert Lasker Award. In collaboration with M. Cara, M.D., D. Jouasset, M.D., C. Duchesne, M.D., and G. Laborit, M.D., J. B. Lippincott Company, Philadelphia, 1959. 255 pages.

As the title indicates the author thinks of the effect of stress on the cells rather than on the extra cellular fluid. The cells maintain a polarized membrane by their metabolic processes. One aspect of this is the retention of K within the cell and exclusion of Na from the inside of the cell. The author considers sympatholytics, insulin plus glucose, neuroplegics, hyperventilation and potassium as factors favoring polarization. Sympathomimetics, sympathetic stimulation, digitalis glycosides, anoxia, hypercapnia, hypothermia and Na ions are listed as depolarizing factors. Readily oxidizable substrates such as glucose must be supplied the cells for the repolarization. "It is the restoration of the rest potential which constitutes the truly active cellular event." There is a section on regulation of the water-electrolyte balance and one on acid-base balance regulation. The author reviews partially investigative methods for ionic and metabolic phenomena, H ion excretory system, and resuscitation of respiratory and cardiac function. There is a considerable discussion of a physiological study of the patient placed under artificial hibernation or under neuroplegia.

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Laborit believes that therapy for stress should promote excretion of sodium. He favors a sodium-free macromolecular liquid, made hypertonic with glucose. The use of packed cells and sodium-free human albumin, he prefers to transfusion with plasma. Enrichment with sodium, he contends, promotes membrane depolarization, escape of potassium and hyperthermia. More experimental evidence is needed to support this therapeutic approach. "Above all, we must insure the restoration of potassium to the cell or its maintenance in it. We shall achieve this by reducing the release of epinephrine and of cortical hormones by means of the neuroplegics. These, when combined with insulin plus glucose and somatropin, will even lend themselves to an increase of the intracellular potassium."

This book is written very clearly and interestingly. It stimulates a great deal of thinking about physiology, including that involved in a patient. —R. C. Herrin, Ph.D.

COMPARATIVE EFFECTS OF RADIATION

Edited by Milton Burton, Chemistry Department and Radiation Laboratory, University of Notre Dame, Ind., J. S. Kirby-Smith, Biology Division, Oak Ridge National Laboratory, Tenn., and John L. Magee, Chemistry Department and Radiation Laboratory, University of Notre Dame, Ind. Report of a Conference held in San Juan at the University of Puerto Rico, February 1960, sponsored by National Academy of Sciences—National Research Council. John Wiley & Sons, Inc., 440 Park Avenue South, New York 16, N. Y., 1960. 426 pages. Price: $8.50.

The book is a composite report on a conference held in 1960 covering the comparative effects of ionizing, ultraviolet, visible, and near infrared radiations. Biologists, chemists, and physicists presented work they had carried out in determining cellular changes induced by the various energy waves.

Discussions which follow each presentation are more interesting and enlightening than the papers presented. The reader is impressed by the fact that the unknowns far outnumber the knowns.

It is a highly technical book which is recommended to those who are engaged in research in this field. —F. F. Gollin, M.D.

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Medical Meetings
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UW Postgraduate Course, Feb. 15

Diseases of the Kidneys and Urinary Tract as Encountered in Pediatric Patients is the subject of a University of Wisconsin postgraduate course to be held at the University Hospitals Feb. 15. Program chairman is Dr. Nathan J. Smith, Professor and Chairman, Department of Pediatrics. Registration fee: $10. Each session of this course has been awarded 3½ hours of Category I credit by the AGP. Write: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

U. of Wisconsin PG Course, Mar. 1–3

Postgraduate course by University of Wisconsin Medical Center, Wisconsin Center building, on "Problems and Perspectives in Medicine." Program chairman: Ovid O. Meyer, M.D., chairman, Department of Medicine, University Hospitals.

Presentation of important new concepts in medicine as they concern basic science and clinical practice by a faculty of guest speakers and members of the medical school staff distinguished in the fields of experimental research and the practice of medicine.

Guest speakers are Dr. Archer P. Crosley, Jr., Director of Clinical Research, Mercy–Douglass Hospital, Philadelphia, Pa.; and Dr. Victor E. Pollak, Research Assistant Professor, Department of Medicine, University of Illinois College of Medicine, Chicago, Ill.

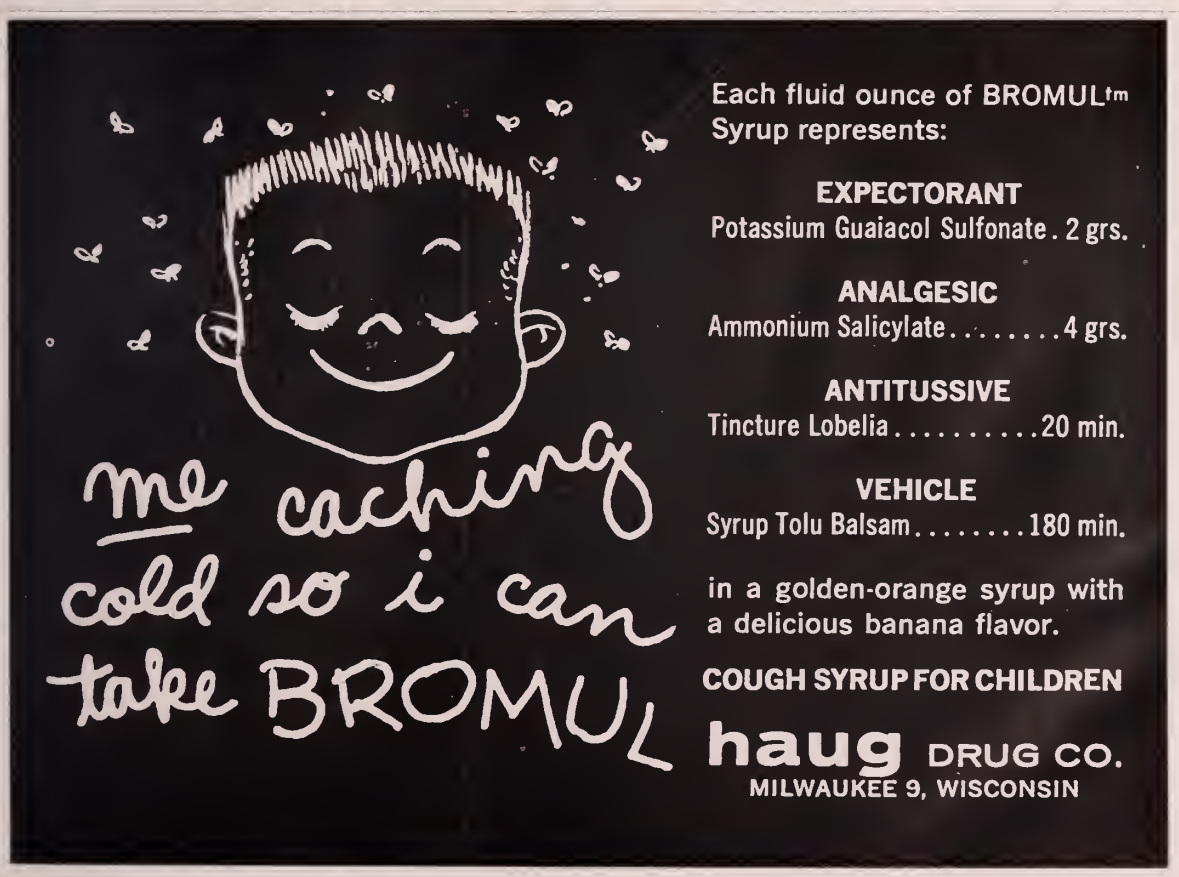
A social hour and conference dinner will be held Friday evening at the Blackhawk Country Club.

Members of the Academy of General Practice will receive 18 hours of Category I credit for the entire 2½-day course. Registration fee: $50. Write: Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6.

Marquette Postgraduate Course, Mar. 7, 14, 21, 28

Marquette University School of Medicine, Milwaukee, offers a postgraduate course on The Modern Approach to Clinical Electrocardiography on Wednesday mornings 9 to 12 o'clock March 7, 14, 21 and 28, Milwaukee County Hospital, 8700 West Wisconsin Avenue, Milwaukee 13. Director: Dr. John H. Huston, Associate Professor of Medicine, Marquette. Program includes a series of lectures and demonstrations on the clinical interpretation of electrocardiograms. American Academy of General Practice

(Continued on page 52)



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'THORAZINE' PRESCRIBING INFORMATION

Because of its pronounced calming effect, 'Thorazine' is an outstanding agent for patients with mental and emotional disturbances, particularly those with symptoms of agitation and hyperactivity. In severe cases, initial use of intramuscular administration may be desirable to control symptoms promptly.

Before prescribing 'Thorazine' for other indications than those given below, the physician should be familiar with the dosage, side effects, cautions and contraindications for such uses. This information is available in the *Thorazine® Reference Manual* and *Physicians' Desk Reference,* and from your SK&F representative or your pharmacist.

ADMINISTRATION AND DOSAGE

Dosage should always be adjusted to the response of the individual and according to the severity of the condition. It is important to increase dosage until symptoms are controlled or side effects become troublesome. In emaciated or senile patients, dosage increases should be made more gradually than in other patients.

ADULT DOSAGE

Mental and Emotional Disturbances (e.g., agitation, excitement, or anxiety)—*Starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. After a day or two, dosage may be increased by increments of 20 mg. to 50 mg. daily, at semiweekly intervals, until maximum clinical response is achieved. Continue dosage at this level for at least two weeks; then it can usually be reduced to a maintenance level. A daily dosage of 200 mg. is "average," but some patients may require substantially higher dosages. Discharged mental patients, for example, may require daily dosages as high as 800 mg. *Starting intramuscular dose* is 25 mg. (1 cc.). If necessary, and if no hypotension occurs, repeat the initial dose in one hour. Subsequent dosages should be oral, starting at 25 mg. to 50 mg. t.i.d.

Alcoholism—Severely agitated patients: *Starting intramuscular dose* is 25 mg. to 50 mg. (1-2 cc.). Repeat initial dose if necessary and if no hypotension occurs. Start subsequent oral dosages at 25 mg. to 50 mg. t.i.d. **Agitated but manageable patients:** *Starting oral dose* is 50 mg., followed by 25 mg. to 50 mg. t.i.d. For ambulatory patients with withdrawal symptoms or sober chronic alcoholics, *starting oral dosage* is 10 mg. t.i.d. or q.i.d., or 25 mg. b.i.d. or t.i.d. Patients in a stuporous condition should be allowed to sleep off some of the effects of the alcohol before 'Thorazine' is administered.

CHILDREN'S DOSAGE

For Behavior Disorders—*Oral dosage* is on the basis of ¼ mg./lb. of body weight q4-6h, until symptoms are controlled (i.e., for 40 lb. child—10 mg. q4-6h). *Rectal dosage* is on the basis of ½ mg./lb. of body weight q6-8h, p.r.n. (i.e., for 20-30 lb. child—half of a 25 mg. suppository q6-8h). *Intramuscular dosage* is on the basis of ¼ mg./lb. of body weight q6-8h, p.r.n. In children up to 5 years (or 50 lbs.)—not over 40 mg./day; in children 5-12 years (or 50-100 lbs.)—not over 75 mg./day except in extreme unmanageable cases. In severe cases, higher dosages than those recommended above may be necessary. In such cases, 50-100 mg. daily has been used and, in older children, as much as 200 mg. daily or more may be required.

IMPORTANT NOTES ON INJECTION

Except for acute ambulatory cases, parenteral administration should generally be reserved for bedfast patients. Parenteral administration should always be made with the patient lying down and remaining so for at least ½ hour afterward because of possible hypotensive effects. The injection should be given *slowly, deep* into the upper outer quadrant of the buttock. If irritation and pain at the site of injection are problems, dilution of 'Thorazine' Injection with physiologic saline solution or 2% procaine solution may be helpful. Subcutaneous administration is not advisable, and care should be taken to avoid injecting undiluted 'Thorazine' Injection into a vein. Intravenous administration is recommended only for severe hiccups and surgery.

'Thorazine' Injection should not be mixed with other agents in the syringe. Because contact dermatitis has been reported with 'Thorazine', nurses or others giving frequent injections should avoid getting the solution on hands or clothing. 'Thorazine' Injection should be protected from light, since exposure may cause discoloration. Slight yellowish discoloration will not alter potency or efficacy. If markedly discolored, the solution should be discarded.

SIDE EFFECTS

The drowsiness caused by 'Thorazine' is usually mild to moderate and disappears after the first or second week of therapy. If, however, drowsiness is troublesome, it can usually be controlled by lowering the dosage or by administering small amounts of dextro amphetamine.

Other side effects reported occasionally are dryness of the mouth, nasal congestion, some constipation, miosis in a few patients and, very rarely, mydriasis.

Mild fever (99°F.) may occur occasionally during the first days of therapy with large intramuscular doses.

Some patients have an increased appetite and gain weight, but usually reach a plateau beyond which they do not gain.

CAUTIONS

Jaundice: The over-all incidence of jaundice due to 'Thorazine' has been low—regardless of indication, dosage, or mode of administration. It appears to be related to duration of therapy. Few cases have occurred in less than one week or after six weeks. The jaundice that has occurred mimics the obstructive type, is without parenchymal damage, and is usually promptly reversible upon the withdrawal of 'Thorazine'. Although the mechanism is not clearly understood, most investigators conclude that it is a sensitivity reaction in susceptible individuals.

There is no conclusive evidence to indicate that pre-existing liver disease makes the patient more susceptible to jaundice. (Patients with known alcoholic cirrhosis have been treated with 'Thorazine' without further alteration of liver function.) Nevertheless, 'Thorazine' should be used with due consideration in a patient with liver disease.

If a patient on 'Thorazine' suddenly develops fever with grippe-like symptoms, his serum should be tested for increased bilirubin or his urine for the presence of bile. If any of these tests are positive, 'Thorazine' should be discontinued.

Because detailed liver function tests of 'Thorazine'-induced jaundice give a picture which mimics extrahepatic obstruction, exploratory laparotomy should be withheld until sufficient studies confirm extrahepatic obstruction.

Agranulocytosis: Agranulocytosis, although rare, has been reported. Patients should be observed regularly and asked to report at once the sudden appearance of sore throat or other signs of infection. If white blood counts and differential smears give an indication of cellular depression, the drug should be discontinued, and antibiotic and other suitable therapy should be instituted.

Because most reported cases have occurred between the fourth and the tenth weeks of treatment, patients on prolonged therapy should be observed particularly during that period.

A moderate suppression of total white blood cells, sometimes observed in patients on 'Thorazine' therapy, is not an indication for discontinuing 'Thorazine' unless accompanied by other symptoms.

Potentiation: 'Thorazine' prolongs and intensifies the action of many central nervous system depressants such as anesthetics, barbiturates and narcotics. Consequently, it is advisable to stop administration of such depressants before initiating 'Thorazine' therapy. Later the depressant agents may be reinstated, starting with low doses, and increasing according to response. Approximately ¼ to ½ the usual dosage of such agents is required when they are given in combination with 'Thorazine'. (However, 'Thorazine' does not potentiate the anticonvulsant action of barbiturates. In patients who are receiving anticonvulsants, the dosage of these agents—including barbiturates—should not be reduced if 'Thorazine' is started. Rather, 'Thorazine' should be started at a very low dosage and increased, if necessary.)

Hypotensive Effect: Postural hypotension and simple tachycardia may be noted in some patients. In these patients, momentary fainting and some dizziness are characteristic and usually occur shortly after the first parenteral dose, occasionally after a subsequent parenteral dose—very rarely after the first oral dose. In most cases, prompt recovery is spontaneous and all symptoms disappear within ½ to 2 hours with no subsequent ill effects. Occasionally, however, this hypotensive effect may be more severe and prolonged, producing a shock-like condition.

In consideration of possible hypotensive effects, the patient should be kept under observation (preferably lying down) for some time after the initial parenteral dose. If, on rare occasions, hypotension does occur, it can ordinarily be controlled by placing the patient in a recumbent position with head lowered and legs raised. If a vasoconstrictor is required, 'Levophed' and 'Neo-Synephrine'★ are the most suitable. Other pressor agents, including epinephrine, are not recommended because phenothiazine derivatives may reverse the usual elevating action of these agents and cause a further lowering of blood pressure.

Antiemetic Effect: The antiemetic effect of 'Thorazine' may mask signs of overdosage of toxic drugs and may obscure diagnosis of conditions such as intestinal obstruction and brain tumor.

Dermatological Reactions: Dermatological reactions have been reported. Most have been of a mild urticarial type, suggesting allergic origin. Some appear to be due to photosensitivity, and patients on 'Thorazine' should avoid undue exposure to the summer sun.

Neuromuscular (Extrapyramidal) Reactions: With very high doses of 'Thorazine', as frequently used in psychiatric cases over long periods, a few patients have exhibited neuromuscular (extrapyramidal) reactions which closely resemble parkinsonism. Such symptoms are reversible and usually disappear within a short time after the dosage has been decreased or the drug temporarily withdrawn. These reactions can also be controlled by the concomitant administration of an anti-parkinsonism agent (see *Physicians' Desk Reference*). Depending on the severity of the symptoms, suitable supportive measures such as maintaining a clear airway and adequate hydration should be employed. When 'Thorazine' is reinstituted, it should be at a lower dosage.

Lactation: Moderate engorgement of the breast with lactation has been observed in female patients receiving very large doses of 'Thorazine'. This is a transitory condition which disappears on reduction of dosage or withdrawal of the drug.

CONTRAINDICATIONS

'Thorazine' is contraindicated in comatose states due to central nervous system depressants (alcohol, barbiturates, narcotics, etc.) and also in patients under the influence of large amounts of barbiturates or narcotics.

SUPPLIED

Tablets, 10 mg., 25 mg., 50 mg. and 100 mg., in bottles of 50, 500 and 5000; 200 mg., for use in mental hospitals, in bottles of 500 and 5000. (Each tablet contains 10 mg., 25 mg., 50 mg., 100 mg., or 200 mg. of chlorpromazine hydrochloride.)

Spansule® capsules, 30 mg., 75 mg., 150 mg. and 200 mg., in bottles of 30, 250 and 1500; also 300 mg., in bottles of 30 and 1500. (Each 'Spansule' capsule contains 30 mg., 75 mg., 150 mg., 200 mg., or 300 mg. of chlorpromazine hydrochloride.)

Ampuls, 1 cc. and 2 cc. (25 mg./cc.), in boxes of 6, 100 and 500. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 6 mg. of sodium chloride.)

Multiple-dose Vials, 10 cc. (25 mg./cc.), in boxes of 1, 20 and 100. (Each cc. contains, in aqueous solution, 25 mg. of chlorpromazine hydrochloride; 2 mg. of ascorbic acid; 1 mg. of sodium bisulfite; 1 mg. of sodium sulfite; 1 mg. of sodium chloride; 2% benzyl alcohol as preservative.)

Syrup, 10 mg./teaspoonful (5 cc.), in 4 fl. oz. bottles. (Each 5 cc. contains 10 mg. of chlorpromazine hydrochloride.)

Suppositories, 25 mg. and 100 mg., in boxes of 6. (Each suppository contains 25 mg. or 100 mg. of chlorpromazine; glycerin, glyceryl monopalmitate, glyceryl monostearate, hydrogenated cocoanut oil fatty acids, hydrogenated palm kernel oil fatty acids, lecithin.)

Concentrate (for hospital use), 30 mg./cc., in 4 fl. oz. bottles, in cartons of 12 and 36, and in gallon bottles. (Each cc. contains 30 mg. of chlorpromazine hydrochloride.)

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MEDICAL MEETINGS *continued*

will allow 12 hours, Category I, credit. Tuition: $30. Write: Joseph W. Rastetter, M.D., Director of Postgraduate Medical Education, Marquette U. School of Medicine, Milwaukee 13, Wisconsin.

American College of Allergists, Apr. 1–6

Graduate instructional course, Hotel Radisson, Minneapolis, Minn. Write: John D. Gillaspie, M.D., treasurer, 2141 14th Street, Boulder, Colo.

Chicago Ophthalmological Society, Feb. 16–17

Annual clinical congress, Drake Hotel, Chicago, Ill. Registration fee for the entire course including round table luncheons and dinner is $45.00 and may be payable to the Registrar: Mrs. Mary E. Ryan, 1150 N. Lorel Avenue, Chicago 51, Ill.

Clinical Reviews, Mayo Clinic and Foundation, Mar. 26–28 and Apr. 2–4

Three-day program of lectures and discussions on problems of current interest in general medicine and surgery. AAGP members attending will receive Category I credit. Registration fee $10. Same program to be presented in two successive weeks. Write: M. G. Brataas, Mayo Clinic, Rochester, Minn.

American Association for the Study of Headache, June 23

Annual meeting, Palmer House, Chicago, Ill. Dr. Bayard T. Horton, Mayo Clinic, Rochester, Minn., president. Write: Lester S. Blumenthal, M.D., Committee on Publicity and Public Relations, 5315 Connecticut Avenue, N.W., Washington 15, D.C.

West Virginia Academy of Ophthalmology and Otolaryngology, Apr. 23–25

Fifteenth annual spring meeting, Greenbrier Hotel, White Sulphur Springs, West Virginia. Registration fee $25. Write: Dr. Worthy W. McKinney, 109 East Main Street, Beckley, W.Va.

Chicago Committee on Trauma of the ACS, Apr. 25–28

Sixth postgraduate course on fractures and other trauma, John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago, Ill. Registration fee $75. Residents and interns admitted free by letter from chief of services. Course is acceptable for 31½ hours of Category II credit by AAGP. Write: Dr. John J. Fahey, 1791 West Howard Street, Chicago 26, Ill.

American Thoracic Society, May 21–23

Annual meeting, scientific sessions on clinical and laboratory work in tuberculosis and other respiratory diseases, Miami, Fla.

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County Society Proceedings

BROWN

At the December 14, 1961, meeting of the Brown County Medical Society, held at the Green Bay Elks Club, the following officers were elected for the 1962 year:

President—*Dr. R. L. Troup*, Green Bay.
President-elect—*Dr. J. E. Dettmann*, Green Bay.
Secretary-treasurer—*Dr. Frank Urban*, Green Bay
Delegates—*Dr. George Nadeau*, Green Bay; *Dr. J. L. Ford*, Green Bay
Alternates—*Doctor Dettmann*, *Dr. L. H. Edelblute*, Green Bay

Dr. E. R. Killeen, Green Bay, is the immediate past president. The 55 physicians present heard speeches by *Drs. C. A. Wunsch*, Green Bay, George Nadeau, Green Bay, and *J. R. Goelz*, Green Bay. Doctor Wunsch briefly discussed the county hospital system, explaining that larger numbers of psychiatric consultations would be needed to lighten the load on Winnebago State Hospital. The Society voted to endorse the program. Doctor Nadeau reported on the delegates' meeting in Appleton December 5. He explained the increased dues for both the AMA and SMS. Doctor Nadeau also congratulated Doctor Wunsch on his recent election to the office of vice-chairman of the Division on Nervous and Mental Diseases of SMS. Doctor Goelz, chairman of the radio committee, announced that the Brown County Medical Society's radio program would be a bi-weekly presentation on Wednesdays between 1:10 and 1:55 p.m. over station WBAY.

Secretary Urban showed a number of slides which emphasized the magnitude of the American labor union in comparison to the American Medical Association. The slides pointed out the fact that the labor union with the lowest income had a larger annual income than the AMA and that Professor Rossiter of Cornell University in his recent book "Politics and Political Parties in the U.S.A." (Cornell University Press) predicted that socialized medicine would be passed by 1973.

The group also viewed a color film on "External Cardiac Massage" which explained a new method of resuscitation developed at Johns Hopkins Medical School.

The Society met January 11 at the Green Bay Elks Club with 60 members present. President Troup announced the appointment of a committee to work for Kerr-Mills implementation in Wisconsin and against the King-Anderson Bill in Washington, D.C. Committee members are: *Drs. D. W. Shea*, chairman, *A. W. Haines*, *J. A. Killins*, *George Nadeau*, and *Frank Urban*, all of Green Bay.

Physicians whose names appear in italic are members of the State Medical Society.

Secretary Urban gave a brief summary of the development and functioning of emergency services in Green Bay. President Troup asked all physicians to continue their support of the bloodmobile.

Scientific speaker for the evening was *Dr. A. A. Lorenz*, Eau Claire, who spoke on "Diagnosis and Treatment of Depression in Office Practice."

CHIPPEWA

Members of the Chippewa County Medical Society heard *Dr. W. A. Mudge* talk on "Diabetes—New Techniques to Possible Prevention and Possible Cures" at their January 16 meeting in Chippewa Falls. Doctor Mudge is clinical instructor at Marquette University School of Medicine, Milwaukee, and has a private practice in Kenosha. His appearance was sponsored by the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

COLUMBIA-MARQUETTE-ADAMS

Members of the Columbia-Marquette-Adams County Medical Society met December 18, 1961, at Lake Delton. The following officers were elected for 1962:

President—*Dr. Fred Gissal*, Wisconsin Dells
President-elect—*Dr. Robert Cooney*, Portage
Secretary-treasurer—Dr. H. L. Conley, Wisconsin Dells

Dr. Ray Rueckert, Portage, is the retiring president. Doctors Cooney and Rueckert were reelected as delegate and alternate delegate to the State Medical Society.

DANE

Members of the Dane County Medical Society were guests of the University of Wisconsin Medical School faculty at the November 14, 1961, meeting. Papers were presented by Dr. Harry Waisman, professor of pediatrics, and *Dr. Kenneth Lemmer*, professor of surgery. Doctor Waisman explained the increased incidence of mentally retarded people in this country. He cited increased errors of metabolism as a significant factor. Doctor Lemmer spoke on carcinoid tumors and the carcinoid syndrome.

Civil defense was the topic under discussion at the December 12 meeting of the Dane County Medical

Society. Donald Heimlich of the Madison Civil Defense Department and Henry H. Barschall, a nuclear physicist, were the speakers. Mr. Heimlich explained the effects of radiation on the human body while Mr. Barschall explained the complex problems of nuclear weapons.

DOOR-KEWAUNEE

New officers for the 1962 year of the Door-Kewaunee County Medical Society are as follows:

President—*Dr. C. W. Stiehl*, Algoma
Vice-president—*Dr. Patricia F. Lanier*, Kewaunee
Secretary-treasurer—*Dr. W. S. Hobson*, Sturgeon Bay
Delegate—*Dr. W. G. Sheets*, Sturgeon Bay
Alternate—*Dr. D. E. Dorchester*, Sturgeon Bay

FOND DU LAC

Fond du Lac County Medical Society voted to expand its civil defense disaster program following a report by two physicians at the November 30, 1961, meeting. *Dr. John Parrish* and *Dr. B. E. Liewen*, members of the disaster committee, who had attended an AMA conference on disaster preparations at Chicago, suggested that the Society enlarge its program and continue to work in an advisory capacity on medical matters in civil defense preparations.

New officers for the 1962 year are:

President—*Dr. D. W. McCormick*, Fond du Lac
President-elect—*Dr. C. M. Flanagan*, Fond du Lac
Secretary-treasurer—*Dr. W. G. Kendell*, Fond du Lac
Delegate—*Dr. D. J. Twohig, Jr.*, Fond du Lac
Alternate—*Dr. W. E. Myers*, Fond du Lac

GRANT

Twenty-two members of the Grant County Medical Society met December 14, 1961, at Lancaster. Dr. Julius Nemmers, orthopedist, of Dubuque, Iowa, was a guest speaker and discussed the subject "Bursitis."

The following officers were elected for 1962:

President—*Dr. Cedric S. King*, Cuba City
Vice-president—*Dr. Charles Steidinger*, Platteville
Secretary-treasurer—*Dr. H. W. Carey*, Lancaster
Delegate—Doctor Steidinger
Alternate—Doctor Carey

During the business session the civil defense hospital unit was discussed.

GREEN

At the December 18, 1961, meeting of the Green County Medical Society the following officers were elected for 1962:

President—*Dr. Philipp Marty*, New Glarus
Vice-president—*Dr. Wayne Fencil*, Monroe
Secretary-treasurer—*Dr. W. J. Staab*, Monroe
Delegate—*Dr. R. G. Zach*, Monroe
Alternate—Doctor Staab

GREEN LAKE-WAUSHARA

The following officers have been elected for 1962 in the Green Lake-Waushara County Medical Society:

President—*Dr. Roger A. Kjentvet*, Wild Rose
Vice-president—*Dr. Alfred T. Leininger*, Green Lake
Secretary-treasurer—*Dr. Roy Hong*, Wild Rose

JEFFERSON

New officers for 1962 of the Jefferson County Medical Society were elected December 21, 1961, as follows:

President—*Dr. Stephen Ambrose*, Whitewater
Vice-president—*Dr. Henry Aufderhaar*, Fort Atkinson
Secretary-treasurer—*Dr. John Becker*, Watertown
Delegate—*Dr. Harvey Mallow*, Fort Atkinson
Alternate—*Dr. Roland Liebenow*, Lake Mills

Dr. Mischa J. Lustok was a guest lecturer at the January 18 meeting held in Jefferson. Doctor Lustok, assistant clinical professor of cardiology at Marquette University School of Medicine, Milwaukee, discussed "Management of Acute Cardiac Arrythmias." His appearance was sponsored by the CES Foundation of the State Medical Society under a grant from the Wisconsin Heart Association.

LA CROSSE

Sixty members of the La Crosse County Medical Society met December 18, 1961, at La Crosse, and elected the following officers for 1962:

President—*Dr. Karl Ruppenthal*, Bangor
Vice-president—*Dr. George Skemp*, La Crosse
Delegate—*Dr. Robert Gilbert*, La Crosse

Dr. Edgar S. Gordon of the University Hospitals, Madison, spoke on "Obesity and Fat Metabolism" at the January 15 meeting held in La Crosse. Doctor Gordon's appearance was sponsored by the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

LAFAYETTE

At the December 19, 1961, meeting of the Lafayette County Medical Society the following officers were elected for 1962:

President—*Dr. N. A. McGreane*, Darlington
Vice-president—*Dr. R. E. Hunter*, Argyle
Secretary-treasurer—*Dr. L. L. Olson*, Darlington
Delegate—*Dr. R. E. Oertley*, Darlington
Alternates—Doctor Hunter; *Dr. D. J. Garland*, Shullsburg

LINCOLN

New officers for 1962 of the Lincoln County Medical Society are:

President—*Dr. J. D. Millenbah*, Merrill
Vice-president—*Dr. Wm. E. Braun*, Merrill
Secretary-treasurer—*Dr. E. O. Ravn*, Merrill
Delegate—*Dr. R. J. Henderson*, Tomahawk
Alternate, *Dr. J. F. Bigalow*, Merrill

At the January 11 meeting, members heard *Dr. A. P. Schoenenberger*, Madison, talk on "Urological Problems in General Practice. Doctor Schoenenberger, who is president of the Dane County Medical Society, appeared through the sponsorship of the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

MARATHON

The annual business meeting of the Marathon County Medical Society was held November 30, 1961. Election of officers for 1962 was held as follows:

President—*Dr. O. R. Kelley*, Wausau
President-elect—*Dr. R. H. Brodhead*, Wausau
Secretary-treasurer—*Dr. G. J. Bachhuber*, Wausau

MILWAUKEE

New officers for 1962 of The Medical Society of Milwaukee County, some of whom were elected at the December 14, 1961, meeting, are as follows:

President—*Dr. Roman E. Galasinski*, Milwaukee
President-elect—*Dr. Robert A. Frisch*, Milwaukee
Treasurer—*Dr. Frederick G. Gaenslen*, Milwaukee
Secretary—*Dr. Francis F. Rosenbaum*, Milwaukee
Delegates—*Drs. R. F. Partell, S. L. Chojnacki, S. E. Zawodny, A. J. Sanfelippo, Edgar End, S. W. Hollenbeck, F. A. Ross, C. M. Schroeder, V. L. Baker, H. F. Twelmeyer, L. R. Weinshel, H. M. Klopf, F. E. Drew, G. W. Hilliard, H. J. Lee, G. E. Collentine, J. F. Cary, W. J. Conen, P. E. Oberbreckling, D. M. Ruch, Norbert Enzer, E. G. Collins, George Murphy, N. G. Bauch, D. J. Carlson*, and *E. L. Bernhart.*
Alternates—*Drs. E. D. Wilkinson, Rex Ruppa, J. R. Evrard, J. J. Barrock, G. W. Dean, R. J. Snartemo, T. J. Cox, K. E. Sauter, R. T. Sproule, D. W. Calvy, W. S. Polacheck, B. J. Peters, P. G. LaBissoniere, T. F. Jennings, W. H. Frackelton, R. S. Haukohl, R. A. Nimz, E. J. Schmidt, A. E. Roethke, K. A. Liefert, R. H. Lillie, F. J. Millen, R. H. Frederick, W. L. Coffey, R. B. Pittelkow*, and *L. E. Rothman.*

ONEIDA-VILAS

A movie on Cardiac Resuscitation was viewed by members of the Oneida-Vilas County Medical Society at its meeting on December 21, 1961, in Rhinelander. Election of officers was also held. The new officers for 1962 are:

President—*Dr. Allen Johnson*, Rhinelander
Vice-president—*Dr. George Pratt*, Rhinelander
Secretary-treasurer—*Dr. Marvin Wright*, Rhinelander
Delegate—Doctor Wright
Alternate—Dr. Lewis L. Jacobson, Eagle River

OUTAGAMIE

Appleton Post-Crescent Photo

Newly elected officers of the Outogomie County Medicol Society ore shown obove, left to right: Dr. Joseph Bonner, president; Dr. Jack Anderson, secretory; ond Dr. Froncis Houch, vice-president; oll of Appleton.

PIERCE-ST. CROIX

The November 28, 1961, meeting of the Pierce- St. Croix County Medical Society was held at Knapp with *Dr. Phil Limberg* as host. On January 16, the Society met near New Richmond.

POLK

New officers for 1962 of the Polk County Medical Society are:

President—*Dr. W. R. Byrne*, Amery
Secretary—*Dr. M. G. Marra*, Amery
Delegate—*Dr. L. O. Simenstad*, Osceola
Alternate—*Dr. R. M. Moore*, Frederic

Dr. Jerome T. Grismer of Minneapolis was guest lecturer at the January 18 meeting held at St. Croix Falls, *Dr. F. B. Riegel*, host. Doctor Grismer, a cardiac and thoracic surgeon at the St. Louis Park Medical Center, discussed indications for cardiac catheterization and illustrated his talk with slides and x-ray films.

Another speaker at the meeting was Mr. Jack Ryon, representative of the AMA, who discussed the King–Anderson Bill. It was also decided at the business meeting to include Mantoux tests with preschool examinations.

Stevens Point Daily Journal Photo

Newly elected officers of the Portage County Medical Society are shown with Dr. Hermon W. Wirka, Madison, professor of orthopedics at the University of Wisconsin, who spoke at the society's meeting January 11. From left are Dr. Austin G. Dunn, president; Dr. Albert Kohn, secretary-treasurer; Doctor Wirka and Dr. Walter Gromowski, vice-president.

PORTAGE

Nineteen members of the Portage County Medical Society met December 7, 1961, at the Whiting Hotel in Stevens Point. New officers for 1962 are:

President—*Dr. Austin Dunn*, Stevens Point
Vice-president—*Dr. Walter Gramowski*, Stevens Point
Secretary—*Dr. Albert Kohn*, Stevens Point
Delegate—*Dr. Francis Gehin*, Stevens Point
Alternate—*Dr. Albin Sowka*, Stevens Point

The group approved the principle of fourth grade physical examinations as required by the State Board of Health. A discussion on the various insurance programs resulted in a recommendation that the Public Relations Committee in its anticipated Medico-Socio-Economic Survey for 1962 study these programs thoroughly and report their findings to the Society. Members also agreed to participate in next year's National Diabetes Week program of giving free urine examinations.

Dr. Herman W. Wirka was a guest lecturer at the January 11 meeting held at the Hot Fish Shop in Stevens Point. Doctor Wirka talked on "Management of Minor Foot Disturbances." A professor of orthopedics at the University of Wisconsin Medical Center, Madison, his appearance was sponsored by the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme. Discussants following the talk were Drs. *F. W. Reichardt* and *F. C. Iber*. Also a guest speaker was *Dr. Robert W. Mason*, Marshfield, who represented the State Medical Society as councilor from the ninth district.

RICHLAND

The November 2 meeting of the Richland County Medical Society was held at the Richland Hospital library in Richland Center. Guest speakers were H. E. Carswell, Ph.D., hospital administrator; and Francis Brewer, attorney. Their subjects concerned hospital administration and local hospital affairs, including the proposed new hospital addition.

SAUK

Dr. A. S. Evans, director of the State Laboratory of Hygiene, Madison, was guest speaker at the December 12, 1961, meeting of the Sauk County Medical Society in Baraboo. His talk was entitled "Common Syndromes of Infectious Disease." Doctor Evans' appearance was sponsored by the CES Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

SHEBOYGAN

New officers elected at the December meeting of the Sheboygan County Medical Society are:

President—*Dr. Willard G. Huibregtse*, Sheboygan
Vice-president—*Dr. Arthur C. Tompsett*, Sheboygan
Secretary—*Dr. Joseph K. Kovacic*, Sheboygan
Delegate—*Dr. J. W. McRoberts*, Sheboygan
Alternate—*Dr. Donald M. Rowe*, Kohler.

TREMPEALEAU-JACKSON-BUFFALO

The annual meeting of the Trempealeau-Jackson-Buffalo County Medical Society was held November 28, 1961, at St. Joseph's Hospital, Arcadia. The following officers were elected for 1962:

President—*Dr. Roland Thurow*, Black River Falls
President-elect—*Dr. Richard Holder*, Black River Falls
Secretary-treasurer—*Dr. John H. Noble*, Black River Falls
Delegate—*Dr. Elmer Rohde*, Galesville
Alternate—*Dr. William Wright*, Mondovi

Dr. Elizabeth Comstock, Arcadia, was named honorary president of the Society and was presented with a gavel in token of appreciation for her long and faithful service to the Society.

WINNEBAGO

New officers of the Winnebago County Medical Society for 1962 are:

President—*Dr. Charles Behnke*, Oshkosh
President-elect—*Dr. Raymond H. Quade*, Neenah
Secretary-treasurer—*Dr. Donald Ryan*, Neenah
Delegates—*Dr. Ernest A. Strakosch*, Oshkosh, and *Dr. Clemens Kirchgeorg*, Neenah
Alternates—*Dr. Stanley Graiewski*, Oshkosh, and *Dr. Harry Colgan*, Neenah

WOOD

New officers for the Wood County Medical Society were elected at the December 7, 1961, meeting held in Wisconsin Rapids. They are:

President—*Dr. G. G. Shields*, Wisconsin Rapids

Vice-president—*Dr. F. J. Gouze*, Marshfield

Secretary-treasurer—*Dr. John W. Rupel*, Marshfield

Delegate—*Dr. E. C. Glenn*, Wisconsin Rapids

Guest speaker at the meeting was Dr. Francis Kruse, Jr., Marshfield clinic neurologist, who discussed the neurological complications of infectious mononucleosis. *Dr. Bahij S. Salibi*, Marshfield, spoke on the misuse of urea in brain injury patients. *Dr. R. W. Mason*, councilor of the ninth district, Marshfield, presented a district report. Thirty-five members were in attendance.

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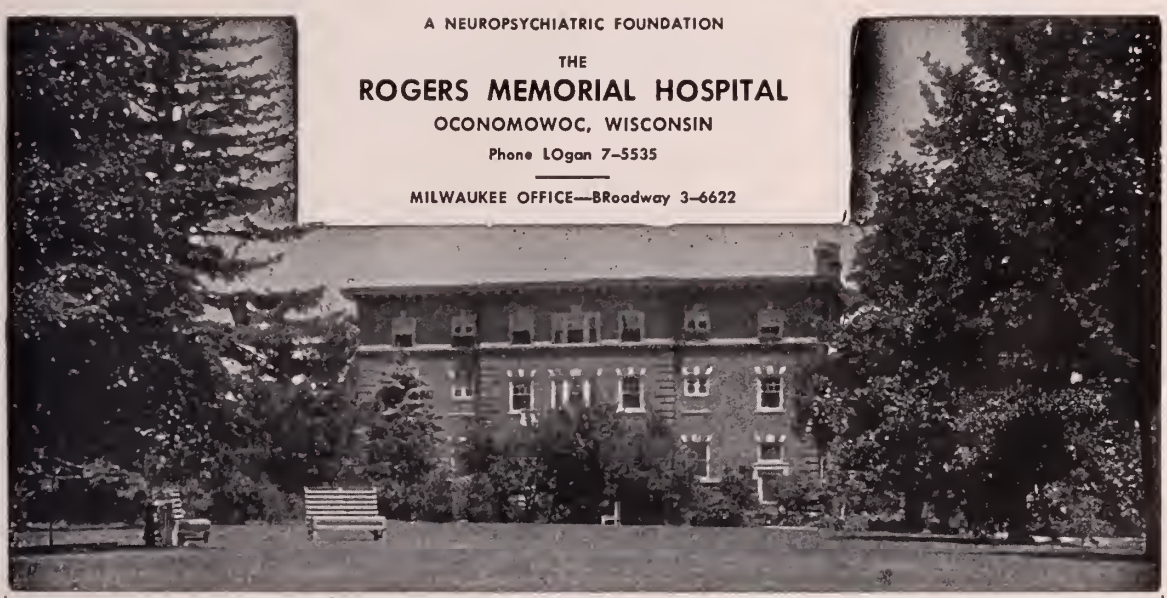

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Codeine phosphate 15 mg.—to relieve local and generalized pain and control dry cough

Neo-Synephrine® 10 mg.—to shrink nasal membranes and open sinus ostia

Acetylsalicyclic acid 300 mg. (5 grains)—to reduce fever and relieve aching

Chlorpheniramine maleate 2 mg.—an antihistamine to shrink engorged membranes and lessen rhinorrhea

Ascorbic acid (vitamin C) 50 mg.—to increase resistance to infections†

New Win-Codin tablets will bring more comfort to many patients suffering from severe colds, influenza or sinusitis.

Average dose: Adults, 1 or 2 tablets three times daily; children 6 to 12 years, from ½ to 1 tablet three times daily.

Available in bottles of 100 (Class B narcotic).

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

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*Trademark †For persons with vitamin C deficiency
Neo-Synephrine (brand of phenylephrine), trademark reg. U. S. Pat. Off.

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Specialty Society Proceedings

Wisconsin Society of Pathologists

At the October 20, 1961, annual meeting of the Wisconsin Society of Pathologists the following officers were elected:

President—*Dr. Frank J. Glassy,* Marshfield
Vice-president—*Dr. David J. Carlson,* Milwaukee
Secretary—*Dr. Robert S. Haukohl,* Milwaukee
Treasurer—*Dr. Chesley P. Erwin,* Milwaukee
Delegate—*Dr. Joseph L. Teresi,* Milwaukee
Alternate—*Dr. Lars Kleppe,* Beloit

Wisconsin Allergy Society

Dr. Konrad Soergel, director of the Gastroenterology Service of Milwaukee County Hospital, addressed the Wisconsin Allergy Society at its annual meeting in November, 1961. His topic was "Autoimmune Phenomena." *Dr. Charles Reed,* new Chief of the Allergy Service at the University of Wisconsin, spoke about the University's facilities and the future plans of his Allergy Service.

Officers elected at the meeting are:

President—*Dr. Frederick Kuehl,* Green Bay
President-elect—*Dr. John Talbot,* Madison
Secretary-treasurer—*Dr. David M. Glassner,* Milwaukee
Past President—*Dr. Harry Weil,* Milwaukee
Program Chairman—Dr. Charles Reed, Madison
Membership chairman—Dr. Harry Weil, Milwaukee

Milwaukee Chapter, Gastroenterology

New officers of the Milwaukee Chapter of the American College of Gastroenterology have been elected for 1962 as follows:

President—*Dr. Philip B. O'Neill,* Milwaukee
Vice-president—*Dr. Charles J. Sherkow,* Milwaukee
Secretary-treasurer—*Dr. Walton D. Thomas,* Milwaukee

Wisconsin Psychiatric Association

The 109 members of the Wisconsin Psychiatric Association have planned their annual scientific meeting for March 2, 3 and 4 at the Northernaire at Three Lakes. Highlights of the program include a major address on "Adolescence" by Dr. C. Knight Aldrich. A panel discussion on "How Can *You* Help Children and Parents" will be presented by Association members, Drs. *Harold Borenz,* Madison; *William Lewis,* Madison; *Robert E. O'Connor,* Madison; and *Charles Raymond Headlee,* Wauwatosa. Dr. *A. A. Lorenz,* Eau Claire, will be the moderator. *Dr. George Andrews* of Wausau will give the Saturday night banquet address on "A Psychiatrist Visits Doctor Schweitzer." *Dr. Carl Kline,* Wausau, is chairman of the event.

Officers of the association are:

President—*Dr. Harold Lubing,* Madison
President-elect—*Dr. Charles Landis,* Milwaukee
Secretary—*Dr. Keith Keane,* Appleton
Treasurer—Dr. Robert O'Connor
Past President—*Dr. Ben Tybring,* Madison

Milwaukee Academy of Medicine

New officers for the Milwaukee Academy of Medicine for 1962 are:

President—*Dr. C. Sherrill Rife*
President-elect—*Dr. Francis F. Rosenbaum*
Vice-president—*Dr. Donald M. Ruch*
Secretary—*Dr. Herbert W. Pohle*
Treasurer—*Dr. Robert A. Frisch*
Librarian—*Dr. F. Jackson Stoddard*

Dr. Shimpei Sakaguchi is the junior member of the membership committee. The senior member and chairman is *Dr. Walton D. Thomas.* Council members include: Drs. *Edward A. Bachhuber, Edward A. Birge, David Cleveland, Frederick E. Foerster, Paul G. LaBissoniere,* and *George C. Owen.*

Dr. William N. Hubbard, Jr., dean of the University of Michigan Medical School, was the featured speaker at the annual meeting held January 16 at the University Club of Milwaukee. Doctor Hubbard spoke on "Changing Patterns in Medical Education."

Wisconsin Society of Internal Medicine

New officers of the Wisconsin Society of Internal Medicine elected at the 1961 fall meeting at Land O'Lakes are:

President—*Dr. Leslie G. Kindschi,* Monroe
President-elect—*Dr. Warren K. Simmons,* Rhinelander
Secretary-treasurer—*Dr. William L. Coffey, Jr.,* Milwaukee
Directors are: Drs. *George E. Gutmann,* Janesville; *Dean B. Becker, Jr.,* Oshkosh; *Edward K. Ryder, Jr.,* Madison; and *Abraham A. Quisling,* Madison.

Physicians whose names appear in italic are members of the State Medical Society.

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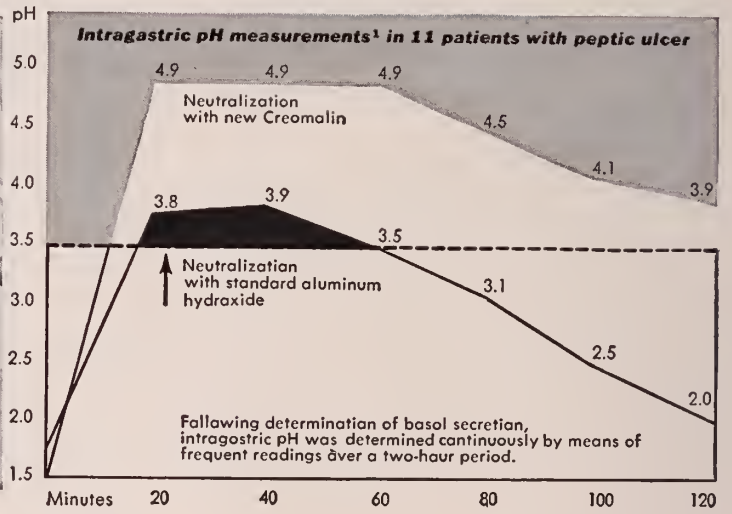
pH 3.5 or above



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Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. New Creamalin tablets are pleasant tasting and smooth, not gritty. They do not cause constipation or electrolyte disturbance.

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How Supplied: Creamalin Tablets, bottles of 50, 100, 200 and 1000.
Also available: New Creamalin Liquid (1 teaspoon=1 tablet), bottles of 8 and 16 fl. oz.

References: **1.** Schwartz, I. R.: *Current Therap. Res.* 3:29, Feb., 1961. **2.** Beekman, S. M.: *J. Am. Pharm. A.* (Scient. Ed.) 49:191, April, 1960. **3.** Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:381, July, 1959. **4.** Data in the files of the Department of Medical Research, Winthrop Laboratories. **5.** Hinkel, E. T., Jr. ; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A.* (Scient. Ed.) 48:384, July, 1959.

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News of Wisconsin Physicians

Frank Cernys to Work in African Mission Hospital

Dr. Frank J. Cerny and his wife, Viola, Fond du Lac, will spend the first four months of this year on a trip around the world which will include work at Kano, Nigeria, West Africa. Doctor Cerny will work as an eye surgeon with Dr. Douglas Hursh, hospital superintendent, whom he met in 1940 while both were in postgraduate training in ophthalmology at the Presbyterian hospital in Chicago. Mrs. Cerny will be engaged as a nurse at the Kano Eye hospital which is supported by the Sudan interior mission. Kano, a city of 400,000 in Northern Nigeria, is predominantly Moslem. Nigeria recently became independent of Great Britain but still has close ties with that nation. Doctor Cerny is a diplomate of the American Board of Ophthalmology and American Academy of Ophthalmology, and is a fellow of the American College of Surgeons.

Doctor Geiger Enters Private Practice

Dr. Sara G. Geiger, a psychiatrist with the Milwaukee county guidance clinic for 25 years and clinic director since 1951, has left the clinic to enter private practice. She served in various Illinois outpatient guidance clinics before coming to Milwaukee in 1936. She has taught criminology, sociology and psychology at the University of Illinois medical school, Loyola university school of social work and Milwaukee-Downer college. A year ago she spoke at the first international conference of the Medical Correction association on organic factors in delinquency.

Doctor James Opens Office at Middleton

Dr. John James, who attended the University of Wisconsin Medical School, has opened his medical office in the Bosco Building, Middleton. Doctor James interned at the Marshfield Clinic, spent two years as a Navy doctor, and after his discharge in 1959 took additional training at Milwaukee County General Hospital.

Oconto Loses Physician to Service

One of Oconto's three physicians, *Dr. George Mohler*, surgeon for the First Battle Group, 127th Infantry headquarters at Appleton, left for Ft. Lewis, Wash., with the 32nd Division of the National Guard.

New Reserve Post for Doctor Curreri

Dr. Anthony Curreri, professor of surgery at the University of Wisconsin, has been transferred from the 44th General Hospital unit and reassigned to a new reserve mobilization designation. In the event of general mobilization, Doctor Curreri will be called to the Surgeon General's Headquarters, U.S. Army, as an assistant to the surgeon general.

Eagle River Memorial Hospital Completes Staff

The staff of the Eagle River Memorial hospital was completed late in October with the arrival of Dr. Vernon H. Bartley of Cincinnati, Ohio. Doctor Bartley has completed four years of surgical residency at hospitals in Cincinnati and is board qualified for general surgery. Before arriving in this country in June of 1957, he completed one and one-half years of resident training in Great Britain where he was born and raised.

Doctor Hudek Heads Hospital Staff

Dr. D. F. Hudek has been selected to serve as president of the Bloomer Community Memorial Hospital medical staff. *Dr. C. T. Clauson* will serve as vice-president; *Dr. M. W. Asplund*, as secretary; and *Dr. P. W. Murphy*, as representative to the hospital board.

Colfax Gets Doctor from Indiana

Dr. Harlan Earnhart of Edinburg, Indiana, has opened his practice in Colfax. He is a graduate of Yale University and of the medical school at the University of Cincinnati. He took his internship at the Cincinnati General Hospital and then spent one year of general practice residency at Miami Valley Hospital in Dayton, Ohio. He was engaged in private practice in Edinburg, Indiana, for 15 months prior to coming to Colfax.

Dr. Covell Heads Racine Hospital Staff

Dr. K. W. Covell has been elected president of the medical staff of St. Mary's Hospital at Racine for 1962. *Dr. W. F. Konnak* is vice-president.

Doctor Jochimsen Takes New Post

Dr. Earl H. Jochimsen, member of the Sheboygan County Guidance Center staff, became director of the Manitowoc Guidance Center January 1. A member of the department of psychiatry at the Sheboygan Clinic and staff psychiatrist with the county

Physicians whose names appear in italic are members of the State Medical Society.

guidance staff, Doctor Jochimsen will travel to Manitowoc Thursdays to direct activities of the center there. He will continue to maintain his schedule in Sheboygan.

Mercy Hospital Elects Officers

Dr. S. A. Freitag was elected chief of the medical staff at Janesville's Mercy Hospital in December. Term of office will be three years. *Dr. E. S. Hartlaub* is staff president, *Dr. F. M. Frechette*, vice-president, and *Dr. Marvin Roesler*, secretary.

Appleton Post-Crescent Photo

Three psychiatrists have been added to the medical staff at Winnebago State Hospital. Shawn with Dr. Charles Belcher, left, superintendent, are Dr. Hugo M. Bachhuber, Dr. Kenneth A. Bittle, and Dr. Carl E. Greuner.

Psychiatrists Join State Hospital Staff

Three fully trained psychiatrists have joined the medical staff of Winnebago State Hospital. They are Dr. Hugo M. Bachhuber, a native of Cashton, who has two previous years of service at the hospital; Dr. Carl E. Greuner, a native of Germany, who will serve as chief of the male continued treatment service; and Dr. Kenneth A. Bittle, a native of Milwaukee, who will serve as chief of female services.

Dr. Jenkinson Honored in Chicago

Dr. Edward L. Jenkinson, Minocqua, was honored by many of his former students at a party at the Palmer House in Chicago in December. The former director of the radiology department of St. Luke's hospital in Chicago, Doctor Jenkinson founded the x-ray department and training school for technicians and was in complete charge of the department for 40 years. He retired a few years ago.

Monroe Physicians Honor Dr. Baumle

Physicians and surgeons at the Monroe Medical Center honored *Dr. C. Earl Baumle* for his 30 years of practice in Monroe at a banquet in December.

Doctor Keuer Joins Medford Staff

Dr. James R. Keuer, Chicago, has joined the Medford Clinic staff. Doctor Keuer, who specialized in general surgery, attended Chicago Medical School and served his internship at Milwaukee County General Hospital and surgical residency at Veterans Administration Hospital at Wood. He has just completed a two-year tour of duty with the U. S. Navy at Key West, Fla.

Doctor Reese Lectures at VA Hospital

Dr. Hans H. Reese, professor of psychiatry and neurology, University of Wisconsin Medical School, Madison, lectured to physicians, psychologists and nurses at the Madison VA hospital in October on "Neurological Diseases that Occur in Infants—Causes and Treatment."

Recognized as an international authority, Doctor Reese spoke as part of the teaching program for staff members. During the past three years he has held special teaching assignments in Greece, Egypt and Japan.

Doctor Vinograd Joins NASA Staff

Dr. Sherman P. Vinograd, Madison, has joined the National Aeronautics and Space Administration as chief of biomedical development in the agency's office of life-science programs, Washington, D.C. A graduate of the University of Wisconsin Medical School, he had been on the staff of St. Mary's and Madison General hospitals and on the teaching staff at University Hospitals.

Doctor Heath Resigns Post in Dodge County

Having served as physician of the Dodge County Hospital and Home since Oct. 1, 1941, *Dr. Harold Heath* resigned his post as of Jan. 1, 1962. Doctor and Mrs. Heath plan to spend a large part of their time in California.

Green Bay Surgeon Aids Vietnamese

Dr. A. L. Freedman, orthopedic surgeon from Green Bay, gave up about six weeks of his practice the end of last year to travel to Saigon and help South Vietnamese crippled by disease or injury. Mrs. Freedman accompanied him after studying French so that she could serve as interpreter. Doctor Freedman participated in the Saigon project as a member of Orthopedic Letters Club Overseas Project. OLCOP was organized early in 1959 and sent its first "ambassadors" to Jordan. Each pays his own way. Averaging as many as 69 operations a month, the surgeons helped the maimed and deformed and

changed many Jordanese ideas of Americans. South Vietnamese surgeons worked with Doctor Freedman and other orthopedic surgeons working there and learned specialized techniques from them.

New Hospital Staff Officers at Oconomowoc

Dr. William D. James is the newly elected chief of medical staff at Memorial Hospital in Oconomowoc with *Dr. J. R. Matt*, vice-president; and *Dr. John D. Wilkinson*, secretary-treasurer.

New Internist Joins Marshfield Clinic

Dr. William V. Dovenbarger, a native of Zanesville, Ohio, has joined the internal medicine staff at the Marshfield Clinic. A graduate of Miami University in Oxford, Ohio, and the Cincinnati College of Medicine, Doctor Dovenbarger interned at Cincinnati General Hospital and then served for two years in the U. S. Army at Brooks Army Hospital, San Antonio, Tex.; Letterman Army Hospital, San Francisco; and the Presidio in San Francisco. He completed his residency in internal medicine at the University of Cincinnati Hospitals late last fall.

Doctor Bowers Attends Conference in Africa

Dr. John Z. Bowers, former dean of the University of Wisconsin Medical School, represented the American Association of Medical Colleges at a conference held at Ibadan, Nigeria, in December. Doctor Bowers is editor of a journal published by the association.

Doctor Wells Locates at Wauwatosa

Dr. Ronald K. Wells, a native of Clinton, is associated with the Wauwatosa Children's Clinic for the practice of pediatrics.

Doctor McGinnis Is President-elect

Dr. James McGinnis has been named president-elect of St. Joseph Hospital medical staff in Superior. *Dr. Louis Rosin* will serve as president during 1962.

Manitowoc Doctor Earns Diploma

The American Board of Obstetrics and Gynecology has announced the awarding of its diploma to *Dr. Thomas S. Arnold* who has been associated with the Manitowoc Clinic since 1954. Doctor Arnold received his M.D. degree from Western Reserve University, Cleveland, Ohio, interned at Millard Fillmore Hospital, Buffalo, N. Y., and completed his residency training at that hospital. He was on active duty with the U.S. Navy before he began his practice in Manitowoc.

Dr. Curreri Quits Cancer Post

Dr. Anthony R. Curreri, Madison, has resigned as director of the University of Wisconsin Medical School's Cancer Research Hospital. He will remain as a professor of surgery. His resignation leaves him with no administrative post in the medical school.

Testimonial Honors Berlin Doctors

Dr. Herman Koch and his son, *Dr. John Koch*, who have contributed a combined total of 30 years of medical service in Berlin, were honored at a testimonial dinner given by the Berlin Lions Club late in December. Dr. John Koch will begin training as a specialist in anesthesia and Dr. Herman Koch will not continue his practice.

Shawano Leader Photo

Dr. Roger C. Cantwell, who completed forty years of medical practice in Shawona in January, is shown with the huge coke which was served when he was honored by staff members ond emplayees of the Cantwell–Peterson Clinic early in January.

Doctor Cantwell Honored

Forty years of continuous service to the city of Shawano and the surrounding area was recognized the first part of January when *Dr. Roger C. Cantwell* was honored by staff members and employees at the Cantwell–Peterson Clinic. Born and raised in Shawano, Doctor Cantwell completed his schooling and internship by 1922 and then returned to his home-town to begin a medical practice which is still continuing. His practice has been devoted to internal medicine, specializing in diseases of the heart and cancer.

Wisconsin Doctors Take Interstate Posts

Dr. N. A. Hill, Madison, was elected secretary of the Interstate Postgraduate Medical Association at its 46th annual meeting in Cleveland, Ohio, Nov. 13–16. He succeeds the late Dr. Erwin R. Schmidt of Madison. Doctor Hill also is a trustee of the organization. *Dr. John M. Bell*, Marinette, was named a trustee of the organization.

Ellsworth Doctors Join River Falls Hospital

Included on the medical staff of the newly organized St. Joseph's Hospital at River Falls are two Ellsworth physicians: *Dr. F. B. Klaas* and Dr. E. R. Jonas.

WISCONSIN PHYSICIANS *continued*

Dr. Rudy Directs Guidance Center

Dr. Warren B. Rudy has been appointed medical director of Marathon County Guild Guidance Center to succeed *Dr. Carl L. Kline.*

Dr. Hitch Elected to Bellin Post

Dr. Oliver M. Hitch has been elected president of the medical staff at Bellin Memorial Hospital.

Doctor Janssen Joins Lakeside Lab.

Dr. William C. Janssen has joined the staff of Lakeside Laboratories, Inc., Milwaukee, as the assistant director of clinical research. Doctor Janssen, a lifetime resident of Milwaukee, recently completed his residency in internal medicine in Milwaukee hospitals. He attended the University of Wisconsin and received his M.D. degree from Marquette University School of Medicine.

W. C. Janssen, M.D.

Baraboo Hospital Doctors Honored

Honored at a Christmas dinner by the Sisters of St. Mary's Ringling Hospital in Baraboo for ten or more years of service as staff physicians were *Dr. A. C. Edwards, Dr. Melvin F. Huth, Dr. K. D. Hannan, Dr. C. R. Pearson, Dr. John H. Houghton, Dr. C. F. Broderick* and *Dr. Frederick W. Gissal.*

Dodgeville Hospital Staff Elected

Dr. W. P. Hamilton, Dodgeville, has been elected president of the Dodgeville General Hospital staff for 1962. *Dr. D. R. Downs,* Dodgeville, is the secretary.

Hayward Hospital Staff Named

At the annual meeting of the Hayward Area Memorial Hospital medical staff in December, *Dr. M. H. Sahs* was elected chief of staff for the coming year. Other officers elected were: *Dr. E. R. Krueger,* vice-chief of staff and *Dr. D. H. Callaghan,* secretary-treasurer.

Changes Made in Marsh Clinic

Dr. W. J. Von Ruden, a member of the Marsh Clinic staff in Shawano since 1954, has left to take a surgical residency at Fort Miley Hospital at San Francisco. A graduate of the University of Illinois College of Medicine in 1952, he will rejoin the staff after completion of his formal training. Dr. Donald Schulz, a native of Wisconsin who is completing his military obligation with the U.S. Army in Pennsylvania, will join the staff early this year.

Dr. Hoberg at Mayo Clinic Course

Dr. Glenn Hoberg, River Falls, attended a postgraduate course for three days at the Mayo Clinic, Rochester, Minn. The course in aviation medicine was sponsored by the Federal Aviation Agency and all of the 97 physicians attending were medical examiners for the Federal Aviation Agency.

Named to Physicians' College

Dr. Murray Herman, specialist in internal medicine at the Ozaukee Medical Center, has been elected to the American College of Physicians. A native of New York, Doctor Herman received his medical degree from New York Medical College and took his residencies with the Veterans Administration in Des Moines, Iowa, and at Wood, Wis. He is an instructor at Marquette University, Milwaukee.

Dr. Gutheil Takes Job at DePere

Dr. D. A. Gutheil has resigned his post as medical director of Maple Grove Sanitorium to take a job in a similar capacity at the Wisconsin Reformatory at DePere. He also will continue as part-time medical director of Hickory Grove Sanitorium near DePere.

Dr. Bemmann Wins "Carol" Award

Dr. Kathryn Chizek Bemmann of Waukesha, formerly of Manitowoc County, was one of five outstanding Wisconsin young women to receive the Carol Award presented at the state convention of the Jaycettes early in December. The "Citation for Achievement and Recognition for Outstanding Leadership" has been given to outstanding women between the ages of 21 and 36 by the Jaycettes since 1957.

Doctor Bemmann completed her residency in psychiatry in June, 1961, and became the first graduate of the new Associated Psychiatric Training Program in Milwaukee. She was also the only woman doctor in the program. She is a full-time member of the medical staff at Milwaukee Sanitarium Foundation, a private, but non-profit, psychiatric hospital in Wauwatosa.

Joins Plymouth Clinic

Dr. Ricardo J. Alvarez joined the staff of the Plymouth Clinic in November, 1961. He is a 1957 graduate of Marquette University School of Medicine, Milwaukee. He served his internship at Detroit Receiving Hospital, Detroit, Mich., and a surgery residency at Akron General Hospital, Akron, Ohio, before entering the Air Force. Since his return from service, he attended the patients of *Dr. R. L. Alvarez,* Galesville, his father, who spent a vacation in his native country, the Philippine Islands.

Diplomates of Board in Public Health

Drs. R. E. Graber, Chippewa Falls, *John Van Susteren*, Onalaska, and *G. G. Shields*, Wisconsin Rapids, have been certified as Diplomates of the American Board of Preventive Medicine in Public Health.

"Socialized Medicine" Subject of Talk

Dr. D. H. Hinke, Richland Center, spoke on "Socialized Medicine" before a public meeting sponsored by the Republican Women of Richland County on November 29. He cited the system in England where after one year's operation costs were nearly triple the original estimate and where one of every 100 persons is employed by the Ministry of Health.

Medical Staff Appointments, Mt. Sinai Hospital

Dr. David V. Elconin, Fox Point, has been named chief of the medical staff of Mount Sinai hospital for a two-year term. Doctor Elconin succeeds *Dr. Joseph Shaiken* who served in the same capacity for four years.

Doctor Elconin was chief of surgery at Mount Sinai, from 1945 to 1956, where he established and directed the first approved residency for surgical training there. He was president of The Medical Society of Milwaukee County in 1955, and is a Diplomate of the American Board of Surgery, a Fellow of the American College of Surgeons and the Wisconsin Surgical Society, and a member of the Milwaukee Academy of Medicine. After graduating from the University of Michigan Medical School in 1925, Doctor Elconin was an intern and house surgeon at Mount Sinai and has been on the hospital staff continuously except for the period of his service with the Army Medical Corps as a Major during World War II.

Other Mount Sinai appointments include *Dr. Marshall L. Weber*, secretary and treasurer; *Dr. Mischa J. Lustok*, head of the Department of Medicine with the following section chiefs: *Dr. I. I. Cash*, Internal Medicine; *Dr. B. J. Malnekoff*, Pediatrics; *Dr. Samuel B. Black*, Neuro-psychiatry; and *Dr. Leonard S. Markson*, Dermatology.

Dr. Sidney K. Wynn heads the Department of Surgery as well as the section of Plastic Surgery, with the following other section chiefs: *Drs. Marvin Wagner*, General Surgery; *Joseph R. Stone*, Orthopedic Surgery; *Jules D. Levin*, Neurosurgery; *Lawrence H. Feiman*, Ophthalmology; *Meyer S. Fox*, Otorhinolaryngology; *Edward B. Jacobson*, Urology; *Leonard J. Schwade*, Proctology; *Benjamin G. Narodick*, Thoracic Surgery; Samuel Granof, Dentistry.

Re-elected heads of departments are *Drs. Alvin M. Kurzon*, Obstetrics-Gynecology; *Eugene J. Ackerman*, General Practice; *Norbert Enzer*, Pathology; *Morris Moel*, Radiology; and *Wilson S. Phillips*, Anesthesiology.

Dayton Hinke, M.D.

D. V. Elconin, M.D.

Additions to Mount Sinai's medical staffing is a new department of Physical Medicine headed by *Dr. Ray Piaskoski* and a new section of Pediatrics Surgery headed by *Dr. Marvin Glicklich*.

The medical executive committee, with Doctor Elconin as chairman, includes department heads Lustok, Wynn, Kurzon, Ackerman, Schwade and *Drs. H. S. Schmacher, A. I. Greenberg* and *Sidney P. Hurwitz*.

Dr. Kalb Presents Paper at Oshkosh

Dr. Clifford H. Kalb, Milwaukee, presented a paper on "Immunologic Basis for Repository Therapy" at the meeting of the Wisconsin Academy of General Practice held in Oshkosh, Nov. 9, 1961.

Dr. Schwade President Proctologic Society

Dr. Leonard J. Schwade, Milwaukee, was elected president of the Tri-State (Illinois-Wisconsin-Indiana) Proctologic Society at its annual meeting held at the Great Lakes Naval Hospital December 6, 1961. *Dr. Leonard Robbins*, Milwaukee, was named secretary-treasurer. Their terms are for the 1962 year.

Hofmeister's Teaching Film Goes Abroad

Dr. F. J. Hofmeister's teaching film, "Cold Knife Conization of the Cervix," has been selected and requested by the American Medical Association to accompany an American medical exhibition which will be on tour in Moscow, Leningrad and a third major Soviet city from February through July, 1962. Previously, March 30 to April 7, 1959, another of his films, "A Complete Office Gynecological Examination," was shown at the Fifteenth General Assembly of The Japanese Medical Congress in Tokyo, Japan.

Dr. Goldstein Sanatorium Medical Director

Dr. David N. Goldstein, Kenosha, has been named medical director of the Willowbrook Sanatorium, Kenosha. He is also coordinator of medical services for all Kenosha County institutions.

WISCONSIN PHYSICIANS *continued*

Dr. Middleton Military Surgeons Officer

Dr. William S. Middleton, medical director of the Veterans Administration, Washington, D. C., has been named a third vice-president of the Association of Military Surgeons of the United States for 1962. The election was held in November, 1961, at the association's annual convention in Washington, D.C.

Mental Health Group Honors Doctor Tenney

Dr. H. Kent Tenney, Jr., Madison, was selected as "Mental Health Citizen of the Year" by the Wisconsin Association for Mental Health at their annual conference in Milwaukee in October. He has been chairman of the advisory commission of the Dane County Association for Mental Health and was on its board of directors.

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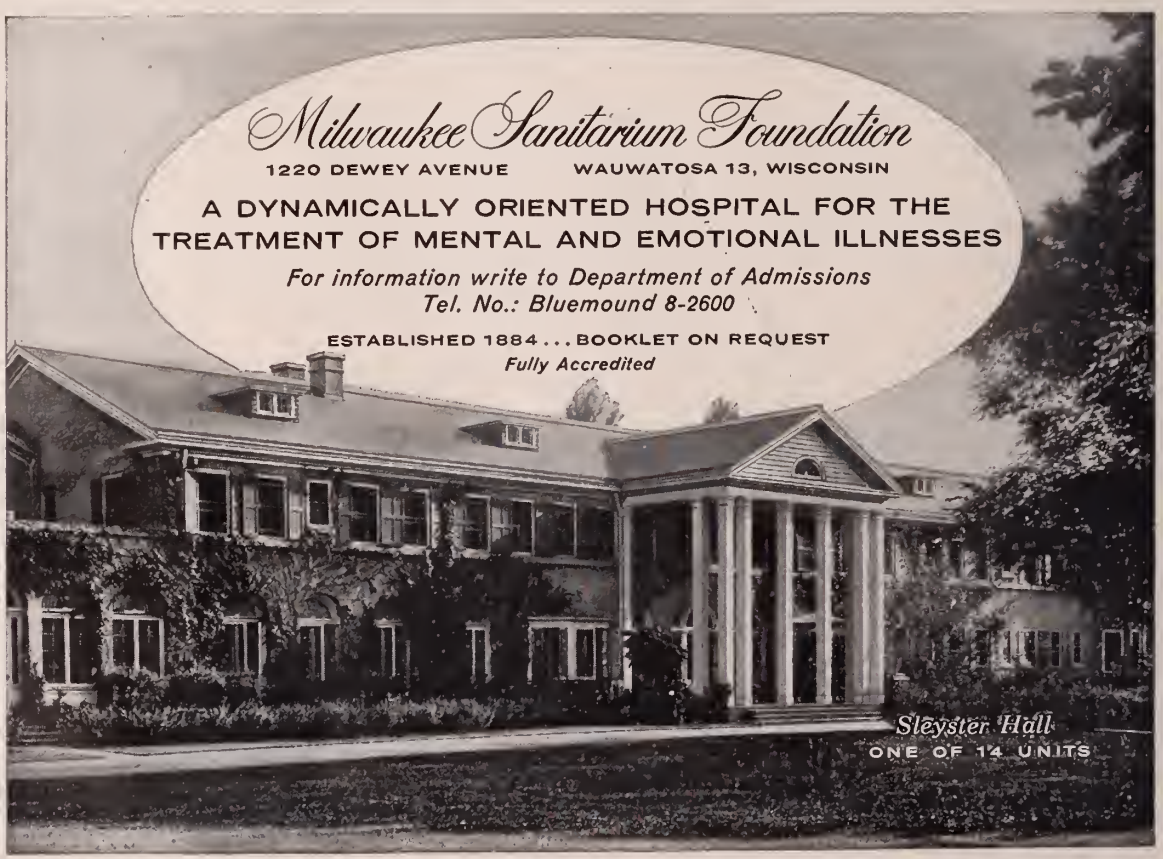

Obituaries

Dr. John A. Heraty, Milwaukee, a specialist in industrial medicine, died September 7, 1961, at the age of 71.

Born in Eden, Wisconsin, Doctor Heraty was a 1914 graduate of Marquette University School of Medicine. A veteran of the Army Medical Corps in World War I, he was physician for Allis Chalmers Manufacturing Company in Milwaukee and conducted a limited private practice.

Doctor Heraty was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Dr. Bernard A. Hoermann, Milwaukee eye, ear, nose and throat specialist, died November 17, 1961, at the age of 85.

Born in St. Louis, Missouri, Doctor Hoermann was a 1901 graduate of the Chicago College of Medicine. He interned at Augustana Hospital in Chicago before establishing his practice in Hartford, Wisconsin, for a time. He moved to Milwaukee in 1903 and practiced until his retirement in 1957.

Active in community affairs, Doctor Hoermann was on the board of directors of the Milwaukee Red Cross Chapter for more than 20 years, was south side chairman for the building of the present St. Luke's Hospital in Milwaukee, was a delegate to the Advisory Council to the Mayor of Milwaukee, and was active in both local and national activities of the Boy Scouts of America, receiving their Silver Beaver Award for distinguished service in 1946.

He was an associate member of the State Medical Society of Wisconsin and a member of the American Medical Association. He was a member of the state society's Fifty Year Club.

Surviving is his widow, Freada.

Dr. Robert J. Hudson, Sauk City, died November 18, 1961, at the age of 63.

A native of Crawford County, Doctor Hudson was a 1924 graduate of the Marquette University School of Medicine. He interned at St. Francis Hospital, La Crosse, and completed his residency at St. Mary's Hospital, Madison. He was in general practice in Prairie du Sac, New Richmond, Madison, and Sauk City during his medical career.

Surviving are four daughters and two sons.

Dr. Forrester Raine, Milwaukee surgeon and one-time member of the State Board of Health, died November 21, 1961, at the age of 61.

Born in Dayton, Ohio, Doctor Raine was a 1924 graduate of Boston University Medical School. Following internship at Mt. Sinai Hospital and residency at Columbia Hospital, both in Milwaukee, he established his private practice in that city.

A veteran of both world wars, Doctor Raine served as chief of staff at the 147th General Hospital, Hawaii, and was surgical consultant for the Central Pacific area in World War II. In addition to his private practice, he was clinical professor of surgery at Marquette University School of Medicine and senior consultant in surgery at the Veterans' Administration Hospital at Wood. He was appointed to the State Board of Health in 1947 and served until 1958.

Doctor Raine was a fellow of the American College of Surgery, a diplomate of the American Board of Surgery, a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, Milwaukee Academy of Medicine, past president of the Milwaukee Surgical Society, past president of the Wisconsin Surgical Society, member of the American College of Surgery and American Association of Thoracic Surgery, a founder member of the American Board of Thoracic Surgery, charter member of the American Board of Surgery, and a member of the Central Surgical Society.

Surviving are his widow, Helen; and one daughter, Mrs. Robert Acton, of Springfield, Ohio.

Dr. E. E. Gallagher, LaCrosse, died November 24, 1961, at the age of 70.

Born in O'Neill, Nebraska, Doctor Gallagher was a 1915 graduate of the St. Louis University Medical School, St. Louis, Missouri. Following internship and residency training at St. Louis City Hospital, he entered military service and was assigned to the British Medical Corps. Upon his return in 1919, he established his practice in La Crosse. He practiced continuously in the community until his retirement in 1959.

Doctor Gallagher was a past president of the La Crosse County Medical Society and a member of the State Medical Society of Wisconsin, the American Medical Association, the Wisconsin Surgical Society, and a fellow of the American College of Surgeons.

Surviving are a sister, Mrs. Agnes Baker, of Casper, Wyoming, and several nieces and nephews, including Dr. Frank Gallagher, of La Crosse.

Dr. Charles R. Marquardt, Milwaukee, a specialist in urology, died December 1, 1961, at the age of 56.

A native of Milwaukee, Doctor Marquardt was a 1930 graduate of Marquette University School of Medicine. He interned at Milwaukee County Hospital and completed his residency there in 1932 at which time he established his practice in that city. He received a Master of Science degree in urology from

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OBITUARIES *continued*

the University of Pennsylvania in 1922. He served at one time as Assistant Clinical Professor of Urology at Marquette University School of Medicine.

Doctor Marquardt was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. A board certified physician in urology, he was a Fellow of the American College of Surgeons, and a member of the American Urological Society, the North Central Branch of the American Urological Society, and the Wisconsin Urological Society.

He is survived by two daughters, Mary of Stephens College, Columbia, Missouri, and Mrs. Charlene Lee, Cambridge, Massachusetts; a sister, Mrs. Emily Knebes; and a brother, Frederick C., Milwaukee.

Dr. Louis V. McNamara, Milwaukee, a general practitioner, died December 7, 1961, at the age of 61.

A native of Hartford, Wisconsin, Doctor McNamara was a 1931 graduate of Marquette University School of Medicine. Following internship and residency training at Milwaukee County Hospital, he established his practice in Montello in 1932. After serving that community for 13 years, he moved to Milwaukee in 1945.

Doctor McNamara was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association. He was Milwaukee County representative on the Board of Directors of the Wisconsin Academy of General Practice from 1952 to 1954.

Surviving are his four children, Mrs. R. F. Purtell, Jr., Mrs. E. R. Rossini, James O., and Dennis L., all of Milwaukee.

Dr. H. C. Alley, Eleva, died December 23, 1961, at the age of 85.

A native of Ontario, Canada, he was a 1909 graduate of the University of Western Ontario medical school, London, Ontario. Following internship at King Edward Sanitarium in London he was resident physician at St. Joseph's Retreat, Dearborn, Michigan, before coming to Eleva in 1912. He practiced in that community until the time of his death, and also served as village and town health officer for a number of years.

Surviving are four sons and one daughter.

Dr. Patrick E. Wright, De Pere, died January 3, 1962, at Marshfield.

A native of Marshfield, Doctor Wright was a graduate of Loyola University Medical School. He had practiced medicine in Wisconsin Rapids from 1927 to 1941, when he moved to Detroit, Michigan, to become superintendent of the Detroit Tuberculosis Sanatorium. He retired from that post in 1960.

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Society Records

Membership Report as of November 30, 1961

NEW MEMBERS

Charles E. Reed, 1300 University Avenue, Madison 6.

John Rankin, 1037 Seminole Lane, Madison.

John R. James, 2011 Mayflower Street, Middleton.

Ronald P. Karzel, 1300 University Avenue, Madison 6.

Emil Schulz, Luther Hospital, Eau Claire.

Harold G. Cooper, 106 East Franklin Street, Appleton.

K. S. George, 231 West Wisconsin Avenue, Milwaukee.

Henry C. LaBrec, V.A. Hospital, Wood.

Marion L. DeVault, 2311 South Meadowlark, New Berlin.

Mel W. Feinburg, 4490 North 84th Street, Milwaukee.

Victoriano A. Baylon, 620 North 19th Street, Milwaukee 3.

Freidrich E. Hoelscher, 5474 North 83rd Street, Milwaukee.

Leo J. Cogan, 836 North 13th Street, Milwaukee.

Paul A. Jacobs, 2040 West Wisconsin Avenue, Milwaukee.

Allan E. Kagen, 759 East Milwaukee Street, Milwaukee.

Geronimo P. Santos, 3232 South 77th Street, Milwaukee.

Neville Sender, 6627 West Capitol Drive, Milwaukee.

Milton B. Spitz, 1028 West Lincoln Avenue, Milwaukee.

Ruth Church, Walworth.

Louis T. Plouff, 319 East Greenfield Street, Appleton.

James P. Mackey, 135 Craig Avenue, Madison.

Herman R. Thomas, Jr. 39 South Main Street, Fond du Lac.

Stewart Lofdahl, Jr., 120 Blossom Street, Ripon.

James F. Hitselberger, 80 Sheboygan Street, Fond du Lac.

James H. Rupple, 80 Sheboygan Street, Fond du Lac.

Frederic G. Haessly, 107 East Center Street, Juneau.

Paul E. Rutledge, Washington Island.

CHANGES OF ADDRESS

Michael G. Yatso, to 1977 South 81st Street, Milwaukee 19.

Charles M. Ihle, to 605 Walker Avenue, Eau Claire.

Nicholas DeLeo, to 6701 West Villard Avenue, Milwaukee 18.

Murray Herman, to 222 South Main Street, Thiensville.

Harry H. Scholmovitz, to 1527 North Marshall, Milwaukee 2.

Benjamin F. Shockley, Jr., to 2654 North 66th Street, Milwaukee 13.

Roger Laubenheimer, to 4213 North Downer Avenue, Milwaukee 11.

Thomas F. McCormick, to 4935 North Ardmore Avenue, Milwaukee 11.

A. F. Haag, to 525 Lincoln Avenue, Eau Claire.

F. N. Pansch, to 211 North Commercial Street, Neenah.

W. H. McGuire, to 189 South High Street, Janesville.

J. J. Seelman, to 2715 North Lake Drive, Milwaukee 11.

Richard L. Wiesen, to 4918 West Blue Mound Road, Milwaukee.

Clinton K. Higgins, to Box 722, La Crosse.

H. A. Devine, Jr., to 2597 Melbourne Avenue, San Diego, California.

Anna L. Standard, to 440 North Galena Street, Milwaukee 12.

Daniel W. Shea, to 1825 South Webster, Green Bay.

Robert M. Wheeler, to 4510 Regent Street, Madison.

C. L. Lacke, to 4017 Monona Drive, Madison 4.

G. R. Anderson, to 211 North Commercial Street, Neenah.

V. G. Springer, to 211 North Commercial Street, Neenah.

Burt R. Erickson, Plum City, to 410 Ross Avenue, Alamosa, Colorado.

Robert E. Bartos, Milwaukee, to 603 North Moreland, Waukesha.

Richard C. Murray, Marinette, to USAH 5027, Fort Benjamin Harrison, Indianapolis 49, Indiana.

Daniel R. Werba, Milwaukee, to 5538 West Monterosa, Phoenix 31, Arizona.

John A. Arkins, Milwaukee, to CO 135, Medical Battalion, 32nd Infantry Division, Fort Lewis, Washington.

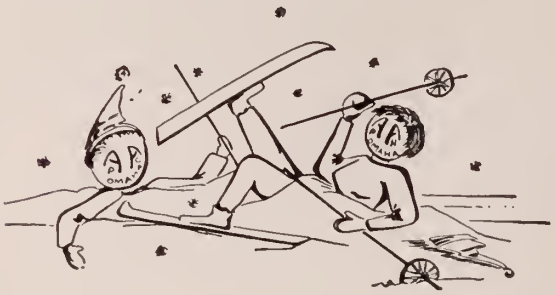
John P. Locksmith, Illinois, to 2400 North Main Street, Clovis, New Mexico.

F. W. Jansen, Green Bay, to 330 Princeton Drive, Costa Mesa, California.

L. O. Lund, Cable, to 4200 East Ninth Avenue, Denver 20, Colorado.

Marvin M. Kirchner, Houston, Texas, to 121 Evacuation Hospital, APO 20, San Francisco, California.

Anthony J. Grueninger, Michigan, to 3443 North Murray Avenue, Milwaukee 11.



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SOCIETY RECORDS *continued*

Sherman P. Vinograd, Madison, to National Aeronautics and Space Administration, 1520 H Street, N.W., Washington 25, D.C.

Thomas E. Bachhuber, Madison, to 11689 Northeast Glisan Street, Portland 20, Oregon.

Carl W. Schmidt, Madison, to Marshall.

B. C. Wheeler, Jr., Madison, to 930 Indiana Avenue, Terre Haute, Indiana.

William C. Janssen, Milwaukee, to 251 North Woodland Lane, Oconomowoc.

Christo Christoff, Milwaukee, to % Olly Weiss, Halensee Str. 7, Berlin, West Germany.

Ross C. Kory, Milwaukee, to V.A. Hospital, Wood.

A. R. Aanes, Ellsworth, to 3810 North Romero Road, Tuscon, Arizona.

Correction

In the December, 1961, issue, page 43, there was an error in the listing of C. J. Schroth. It should have been: George J. Schroth, 808 Third Street, Wausau.

In the January, 1961, issue of the Journal, in the listing of members of the State Medical Society, the name of Nik Nevin, Ismail, Rhinelander, was incorrectly listed on page 72. The correct name is: Ismail Nik Nevin, M.D.

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Medical Meetings

Postgraduate Courses

Marquette Postgraduate Course

A course on "The Modern Approach to Clinical Electrocardiography" will be presented by the Department of Postgraduate Medical Education of Marquette University School of Medicine on Wednesday mornings from 9 to 12 during March, on March 7, 14, 21 and 28, at Milwaukee County Hospital. Director is John H. Huston, M.D. A series of lectures and demonstrations on the clinical interpretation of electrocardiograms will be presented. American Academy of General Practice will allow 12 hours of Category I credit. Tuition: $30. For further details contact Joseph W. Rastetter, M.D., Director of Postgraduate Medical Education, Marquette, Milwaukee 13, Wisconsin.

UW Postgraduate Courses

"Common Orthopedic Problems Occurring in General Practice" will be presented March 8 at University Hospitals. Program chairman: Herman W. Wirka, M.D. Registration: $10. Each session has been awarded 3½ hours of Category I credit by the AAGP.

On April 5–7 a postgraduate course on "Genetics in Pediatrics" will be presented under direction of Nathan J. Smith, M.D., at the Wisconsin Center building. Visiting faculty include: Barton Childs, M.D., Johns Hopkins University of Medicine; F. Clarke Fraser, M.D., McGill University School of Medicine; Tibor J. Greenwalt, M.D., Milwaukee Blood Center; and Arthur G. Steinberg, M.D., Western Reserve University. Registration: $50. Members of AAGP will receive 18 hours of Category I credit for entire 2½-day course.

Upper Peninsula Annual Meeting

The Upper Peninsula of Michigan Medical Society will have its annual meeting at the Gateway Hotel, Land O' Lakes, June 15, 16, 17. First two days will be devoted to a variety of timely medical subjects embracing the whole field, and the third day will be a meeting through courtesy of Lederle Laboratories; this also will include timely subjects of general interest to the medical profession. A program for ladies is also contemplated.

Cancer, Chemotherapy and the Nurse

A professional conference for nurses will be held Saturday, March 17, from 9 a.m. to 5 p.m. at the Wisconsin Center to educate, orient and enlighten nurses on present day concepts of cancer, especially new means of therapy and resultant obligations and challenges. This type of training of nurses can be most helpful to physicians who will be handling more and more cancer problems, especially of a chemotherapy type. The conference is co-sponsored by the American Cancer Society, Wisconsin Division and the Cancer Research Division, Department of Surgery, University Hospitals. For further details write the American Cancer Society, Wisconsin Division, Box 1626, Madison 1.

American Academy of General Practice

Fourteenth Annual Scientific Assembly of the AAGP is scheduled for April 9–12 in Las Vegas, Nev. Backache, appendicitis, "Death with dignity" and "undetected murder", are some of the topics to be discussed.

American College of Physicians

Forty-third Annual Session in Philadelphia, April 9–13.

WISCONSIN STATE DENTAL SOCIETY

ANNUAL SESSION • APRIL 30–MAY 2

MILWAUKEE AUDITORIUM

Members of the State Medical Society of Wisconsin are invited by H. O. Hoppe, D.D.S., president of the Wisconsin State Dental Society. Theme is "Countdown for Dentistry in the Space Age." Guest badges obtained in registration area of Kilbourn Avenue entrance. Need current medical society membership card for identification.

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the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

VOL. 61, NO. 3—MARCH 1962

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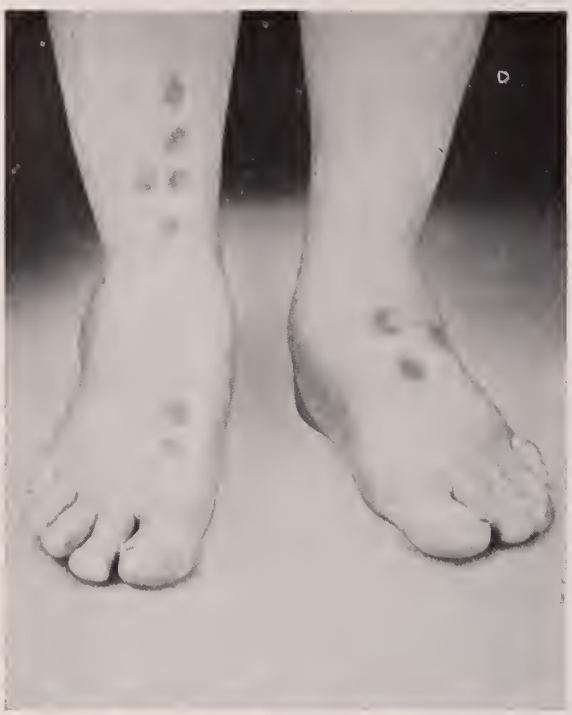

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County Society Proceedings

BARRON—SAWYER—WASHBURN—BURNETT

Twenty members of the Barron-Sawyer-Washburn-Burnett County Medical Society met at Rice Lake January 9 to hear Mr. Jack E. Ryon, field secretary of A.M.A. American Medical Education and Research Foundation, discuss the King-Anderson and Kerr-Mills Bills. *Dr. E. P. Engels,* Rice Lake, presented interesting cases with discussion of x-ray findings and methods of radiographic identification of colonic polyps.

During the business session, methods of informing the public on the advantages of the Kerr-Mills Act were discussed and committees were appointed. It was decided to send a monthly newsletter to all members. Newly elected officers for 1962 are:

President—*Dr. R. M. Anderson,* Cumberland
Vice-president—*Dr. H. O. Jirsa,* Cumberland
Secretary-treasurer—*Dr. M. C. Roller,* Chetek
Delegate—*Dr. C. J. Strang,* Barron
Alternate—*Dr. R. E. Lund,* Cumberland
Censor—*Dr. James F. Maser,* Rice Lake

Members of the Barron-Washburn-Sawyer-Burnett County Medical Society met at the Land O'Lakes Hotel at Rice Lake February 13 to hear Dr. Walter Indeck, Shiller Park Medical Center, Minneapolis, speak on "Shoulder Pain." A resolution was unanimously approved to oppose the King-Anderson Bill. The hospital award program of the State Medical Society was also discussed.

BROWN

Dr. Harry Perry of the Mayo Clinic, Rochester, Minn., spoke on "Common Dermatoses" before the Brown County Medical Society meeting February 5, in Green Bay.

CHIPPEWA

Members of the Chippewa County Medical Society heard *Dr. C. Weir Horswill,* Madison obstetrician, speak on "Hemorrhage as a Leading Cause of Maternal Deaths" at their February 6 meeting in Cornell. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Bureau of Maternal and Child Health, Wisconsin State Board of Health.

DANE

The Seventh Annual Medical-Press Dinner was held on February 9 at the Embers restaurant in Madison in lieu of the regular February meeting of the Dane County Medical Society. Mr. Robert W. Kastenmeier, Wisconsin's second district congressman, was the guest speaker.

Dr. Philip Pacey Cohen, acting dean of the University of Wisconsin Medical School, was elected to honorary membership in the Dane County Medical Society in January. A native of Derry, N. H., Doctor Cohen received his B.A. degree at Tufts College and Ph.D. and M.D. degrees at the University of Wisconsin. He was a teaching assistant at Wisconsin from 1930 to 1938, and a National Research Council fellow at Yale. Doctor Cohen was named assistant professor at Wisconsin in 1941, associate professor in 1944, and a full professor in 1948 when he became chairman of his department. He is the author of numerous research papers in technical journals in his fields of enzymology, protein fractionation and intermediary nitrogen metabolism.

DODGE

The Beaver Dam Medical Forum met at the Pyramid club February 17 to hear Dr. C. E. Rupe, Detroit, specialist in internal medicine at Henry Ford Hospital, speak on "Collagen Diseases."

Beaver Dam Daily Citizen Photo

Dr. C. E. Rupe, Detroit, Mich., left, is shown with Dr. J. A. Szweda, Dr. Robert E. Urbanek and Dr. G. G. Drescher of Beaver Dam Medical Forum.

DOUGLAS

Dr. Dean Emanuel, head of the department of internal medicine of the Marshfield Clinic, spoke before the Douglas County Medical Society at its February 7 meeting in Superior. His topic, "Ad-

Physicians whose names appear in italic are members of the State Medical Society.

vances in the Treatment of Hypertension," was chosen in connection with the heart fund drive in February.

FOND DU LAC

Dr. M. C. F. Lindert, Milwaukee, spoke before members of the Fond du Lac County Medical Society January 29. He stated that medical and surgical aspects of jaundice have emphasized the necessity for complete evaluation of the liver and biliary system by extensive laboratory testing as well as complete and careful medical history. The appearance of Doctor Lindert, who is associate clinical professor of medicine at the Marquette University School of Medicine, was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the postgraduate teaching program of Merck Sharp & Dohme.

LANGLADE

Members of the Langlade County Medical Society heard a talk by *Dr. F. J. Hofmeister,* associate clinical professor of obstetrics and gynecology at Marquette University, at its regular meeting February 5 at the Langlade County Memorial Hospital. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

MILWAUKEE

Dr. H. Close Hesseltine, Mary Campeau Ryerson professor of obstetrics and gynecology at the University of Chicago, addressed the March 8 meeting of The Medical Society of Milwaukee County at the Wisconsin Club. Doctor Hesseltine spoke on "Modern Therapy for Vaginal Discharge."

OUTAGAMIE

Sixty-six members of the Outagamie County Medical Society met at the Conway Hotel in Appleton January 18. Discussants included *Dr. L. H. Lokvam,* Kenosha, president of the State Medical Society; *Dr. H. J. Kief,* sixth district councilor; Mr. C. H. Crownhart, secretary, State Medical Society, and Mr. H. L. Toser, director, Wisconsin Physicians Service.

PIERCE–ST. CROIX

Officers who will serve the Pierce-St. Croix County Medical Society during 1962 are as follows:

President—*Dr. Howard J. Laney,* Prescott
Vice-president—*Dr. A. W. Limberg,* Glenwood City
Secretary-treasurer—*Dr. P. H. Gutzler,* River Falls
Delegate—Doctor Gutzler
Alternate—*Dr. O. H. Epley,* New Richmond

The Society met February 20 at Hotel Dibbo in Hudson.

PORTAGE

Members of the Portage County Medical Society heard *Dr. Helen A. Dickie,* professor, department of medicine, University of Wisconsin, talk on "Tuberculin Conversion: Its Therapeutic Challenge" at their meeting at Stevens Point February 8. Her appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Anti-Tuberculosis Association.

SAUK

Dr. J. H. Houghton, Wisconsin Dells, spoke on "Surgical Care" before the February 13 meeting of the Sauk County Medical Society held at the Warren Hotel in Baraboo. At the January 9 meeting, the group heard *Dr. Milton Miller,* University Hospitals, Madison, talk on "Psychiatry." During the business session, discussions were held on the Milwaukee County Medical Society's Surgical Care plan for participating physicians, teenagers working in hospitals, and the dues increase.

WALWORTH

Fifteen physicians and twelve of their wives met at the Village Inn in Delavan for the January 18 meeting of the Walworth County Medical Society. *Dr. John Linn,* Milwaukee, spoke on "Uses and Abuses of Hormones in Obstetric and Gynecologic Practice." The group passed a resolution opposing the Milwaukee County Medical Society's Surgical Care plan relative to participating physicians and the fee schedule.

WAUKESHA

"The Nature of Man" was the topic of Jacob VanTuinen, professor of philosophy at Carrol College, Waukesha, when he spoke to the Waukesha County Medical Society and Auxiliary February 14 at the Club Leilani, Brookfield. Preceding the talk, auxiliary members at a meeting conducted by Mrs. Loren Driscol, Oconomowoc, president, voted to contribute $50.00 toward a medical careers scholarship fund sponsored by the State Medical Society.

WINNEBAGO

Members of the Winnebago County Medical Society were guests of the Winnebagoland Pharmaceutical Society at a dinner meeting at the Athearn Hotel, Oshkosh, February 15. The two groups heard Stuart Erickson, Ph.D., University of Wisconsin school of pharmacy, talk on "Monoamine Oxidase Inhibitors."

Specialty Society Proceedings

Wisconsin Academy of General Practice
Eau Claire-Chippewa Falls Chapter

Four 4-hour medical refresher courses for physicians of the area were scheduled for Thursday evenings during February by the Eau Claire-Chippewa Falls chapter of the Wisconsin Academy of General Practice. Held at Luther Hospital, Eau Claire, the lectures covered cardiovascular disease and hypertension, hematology, and pulmonary disease. Guest lecturers were from the University of Minnesota Medical School.

Each member of the Academy of General Practice who attended received credit necessary for continued membership in the organization.

Wisconsin Psychiatric Association

The Southern Chapter was host to the entire Wisconsin Psychiatric Association at a dinner meeting in Madison at the home of *Dr. Harold Lubing*, chapter president, in January. Judge Edwin E. Wilkie and Prof. Frank J. Remington of the University of Wisconsin Law School discussed the Esser trial.

Milwaukee Academy of Medicine

"Association to the Sonnets" was the subject of the Arthur Wilson Rogers Memorial lecture given by Dr. Charles D. Aring before the Milwaukee Academy of Medicine February 20 at the University Club in Milwaukee. Doctor Aring is professor of neurology at the University of Cincinnati College of Medicine.

Milwaukee Academy of General Practice

Dr. William C. Curtis, Wauwatosa, was elected president-elect of the Milwaukee Academy of General Practice at the annual meeting January 30 at the Milwaukee Athletic Club. *Dr. Steve L. Chojnacki* is the 1962 president, replacing *Dr. Norbert Bauch*, outgoing president.

More than 200 physicians and guests attended the dinner meeting and heard Lt. Cmdr. Earl H. Ninow, New London, Conn., discuss "Psychiatry and Nuclear Submarines." Doctor Ninow, a native of Chilton, is the only psychiatrist in the submarine service.

Other 1962 officers elected included:

Secretary—*Dr. Eugene M. Kay*, Milwaukee
Treasurer—*Dr. Edmund J. Schmidt*, Milwaukee
Directors—*Drs. Morris Mitz, Howard M. Klopf, John A. Kelble*, and *Samuel A. Graziano*, all of Milwaukee
Delegate to Wisconsin Academy of General Practice—*Dr. John F. Cary*, Milwaukee
Alternate—Doctor Kay

Physicians whose names appear in italic are members of the State Medical Society.

Wisconsin Academy of General Practice
Madison Chapter

Speakers at the mid-winter medical symposium of the Madison chapter of the Wisconsin Academy of General Practice held in the Holiday Inn at Madison February 15 were *Dr. Fred Ansfield*, University of Wisconsin; *Dr. Richard C. Wixson*, Madison; Dr. M. Edward Davis, University of Chicago; and Dr. Evan W. Thomas, Public Health Service of Chicago.

Milwaukee Oto-Ophthalmic Society

Members of the Milwaukee Oto-Ophthalmic Society met January 23 at the University Club of Milwaukee. *Dr. Thomas W. Grossmann*, ENT resident at Wood Veterans Administration Hospital, addressed the group following a laryngectomy cine fluorographic study. An anterior segment photographic presentation was given by eye residents of Milwaukee County Hospital.

The Milwaukee Oto-Ophthalmic Society, which met February 27 at the University Club of Milwaukee, heard *Dr. Jules Levin*, associate clinical professor of neurosurgery, Marquette University School of Medicine speak on "Neurosurgical Appraisal of Some Eye, Ear, Nose and Throat Problems."

Milwaukee Pediatric Society

Newly elected officers of the Milwaukee Pediatric Society are:

President—Dr. Ted S. Buszkiewicz, Milwaukee
Vice-president—*Dr. David J. Zubatsky*, Milwaukee
Secretary-treasurer—Dr. John W. Harkness, Wauwatosa

Wisconsin Heart Association
Winnebago County Council

The Winnebago County Council of the Wisconsin Heart Association sponsored a one-day seminar on "Heart Diseases Amenable to Surgery Today" March 29. Physicians from Brown, Calumet, Fond du Lac, Green Lake, Manitowoc, Outagamie, Sheboygan, Waushara and Winnebago counties attended the seminar which was held at Mercy Hospital in Oshkosh.

Dr. Walton Lillehei, professor of surgery, University hospitals, Minneapolis, spoke on "The Changing Outlook in Heart Disease." *Dr. Melvin G. Apell*, Oshkosh pediatrician, moderated the panel on "Diagnostic Approaches" in which all program speakers participated.

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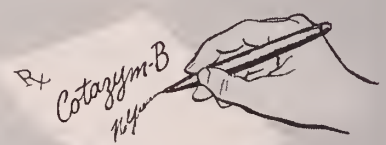

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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News of Wisconsin Physicians

Clintonville Staff Elects Officers

Dr. William G. Arnold has been elected president of the Clintonville Community hospital's medical staff for 1962. *Dr. Owen E. Larson* is the new vice-president and *Dr. Harry Caskey* is secretary and treasurer.

Dr. Nordby Heads Madison General Staff

Dr. E. J. Nordby was elected chief of the medical staff of Madison General hospital January 30. Other officers elected are *Dr. Theodore J. Nereim*, vice-chief of staff; *Dr. Donald G. Dieter*, secretary-treasurer, and *Dr. Palmer K. Kundert*, representative to the Dane County Medical Society board of trustees.

Elected chiefs of their departments are *Dr. Charles E. Doehlert*, medical section; *Dr. John P. Malec*, surgery; *Dr. Walter L. Washburn*, general practice; *Dr. Donald O. Price*, obstetrics and gynecology; and *Dr. William H. Ylitalo*, pediatrics.

Dr. Waldkirch Honored for Civic Work

Dr. R. M. Waldkirch was one of five DePere citizens honored by the DePere Chamber of Commerce in October for outstanding contributions to community development. Doctor Waldkirch was cited for his sponsorship of commercial development in the downtown district.

Dr. McCarty Addresses Nurses

Dr. Robert McCarty, Milwaukee, spoke on "The Care of the Colostomy Patient" at the January 8 meeting of the Waukesha District Nurses Association.

Dr. Baldwin Speaks to Women's Club

Dr. Elizabeth Baldwin, Marshfield, spoke to the Loyal Women's Study club January 8. Her topic was uterine cancer.

Dr. Bowers to Study in Far East

Dr. John Z. Bowers, Madison, and his family will leave in June for a year of travel and study in six Far Eastern countries under terms of an Alan Gregg Travel Fellowship in Medical Education. He was awarded the grant by the China Medical Board, an agency of the Rockefeller Foundation. He will be based in Kyoto, Japan. The fellowship provides him with an opportunity to study and report to American medical schools on medical education in the Orient. Many of his reports will be written for the *Journal of Medical Education*, of which he is editor.

Menomonie Hospital Staff Elects

The medical staff of St. Joseph-Lloyd hospital, Menomonie, has elected the following officers for 1962: Dr. Robert C. Olson, Menomonie, president; *Dr. J. W. Boren, Jr.*, Marinette, president-elect, and *Dr. Antoine Barrette*, Peshtigo, secretary.

Practice Set Up in Florence

Dr. Robert Stelle, Crystal Falls, who has been practicing in Florence Tuesday and Friday mornings, is establishing a permanent part-time office there.

Assistant Director Named at Ripon

Dr. A. C. Bachus has been appointed assistant medical director of the Ripon Cerebral Palsy and Rehabilitation Center.

Dr. Martens on Army Duty

Dr. Thomas J. Martens, Athens, left for Army service in Texas the middle of January.

Doctor Zmolek Talks to Nurses

Dr. E. J. Zmolek, Oshkosh, discussed head injuries during the fifth session of the current series in a disaster nursing course for registered nurses at Mercy Hospital, Oshkosh, February 6. The course is being conducted through the auspices of the Winnebagoland District Nurses Association.

Dr. Borenz Addresses HEED

Dr. Harold F. Borenz, associate professor of psychiatry and director of child psychiatry division of the University of Wisconsin Medical School, discussed "Understanding the Behavior of Emotionally Disturbed Children" at the January 24 meeting of HEED (Help for the Education of Emotionally Disturbed Children) in Madison.

Medical Assistants Hold Symposium

Dr. T. H. McDonnell, Waukesha, and Attorney Norman Skogstad, Milwaukee, discussed "Medico-Legal Problems" at the third educational symposium of the Wisconsin State Medical Assistants Society January 13. The meeting was held at Marquette University's Brooks Memorial Union.

Dr. Russell Addresses Rotarians

Dr. James Russell, Fort Atkinson, addressed the Watertown Rotary Club at its weekly luncheon meeting January 8.

Physicians whose names appear in italic are members of the State Medical Society.

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WISCONSIN PHYSICIANS *continued*

Dr. Ousley is Staff President

Dr. Joseph L. Ousley, Marshfield, was re-elected president at the annual meeting of St. Joseph's Hospital medical staff held in Marshfield January 16. Also re-elected were *Dr. Thomas J. Rice,* vice-president, and *Dr. Robert Taylor,* secretary.

Dr. Byrne Speaks to Mothers Club

Dr. William Byrne spoke to the Kindergarten Mothers Club of Amery January 15. His subject was "Childhood Communicable Diseases."

Edgerton Physician Attends Mayo Course

Dr. David A. Cohen, Edgerton, attended the postgraduate course in Clinical Rheumatology January 22, 23 and 24 at the Mayo Clinic, Rochester, Minn. This is the third Mayo Clinic postgraduate course Doctor Cohen has attended within the past three years.

Physicians-Nurses Hear Dr. Ansfield

"The Medical Considerations Governing Pre-employment, Screening, and Work Assignment in Industry; Their Importance in Prevention of Injury," was the topic of *Dr. David Ansfield,* Milwaukee, when he spoke before the Annual Physicians' and Nurses' Night meeting of the West Allis Industrial Safety Council February 5.

New Richmond Physician Takes Bride

Dr. James Langemo Craig, New Richmond, was married to Miss Carolyn Jean Adams, Hammond, on December 27. Doctor Craig was graduated from the University of Wisconsin Medical School and is affiliated with the New Richmond Clinic. Mrs. Craig was graduated from the University of Wisconsin School of Nursing and is a public health nurse in St. Croix county.

Dr. Moffet Has New Offices

Dr. Dale Moffet, Crandon, has moved into his new professional medical office building in front of his residence. The building does not contain hospital facilities but will be used for emergency and outpatient care.

Curative Center Gets Coordinator

Dr. Alfons Busza, a physical medicine and rehabilitation specialist, has been named medical coordinator of the Adult Rehabilitation Center of the Curative Workshop of Milwaukee. Doctor Busza received his medical degree from the University of Posnam medical school in 1935. He left Poland to join the Polish army in England in World War II. He was a senior assistant in pathology at the Polish medical school of the University of Edinburgh.

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* But please try to give at least three weeks' notice.

He came to the United States in 1955 and served a year as chief resident of the medical division at Goldwater Memorial Hospital in New York. For the last two years, he was clinical director at New York State Rehabilitation Hospital, West Haverstraw, N. Y.

Dr. Garner Addresses Two Groups

Dr. Lawrence L. Garner, director of the Glaucoma Consultation and Referral Center, Marquette University School of Medicine, and ophthalmologist, Veterans Administration, regional office, Milwaukee, addressed the Occupational Health Section of the Wisconsin Nurses Association at the twentieth Wisconsin Mid-Winter Safety Conference held at the Schroeder Hotel, Milwaukee, January 18. Subject of the presentation was the "Role of the Nurse in Glaucoma."

On February 9, Doctor Garner addressed the Minnesota Academy of Ophthalmology at St. Paul, Minn. His subject was "Tonography, a New Technic in the Diagnosis and Treatment of Glaucoma."

Dr. Pierpont Named Chief of Staff

Dr. John Pierpont, Montreal, has been named chief of the medical staff of Grand View hospital at Hurley. Other members are Dr. A. C. Gorrilla, Ironwood, vice-chief of staff; Dr. P. J. Murphy, Ironwood, secretary, and Dr. R. R. Harrington, Ironwood, *Dr. D. J. Martinetti*, Hurley, and Dr. F. J. Santini, Ironwood, members of the executive committee.

Stoughton Has New Clinic Building

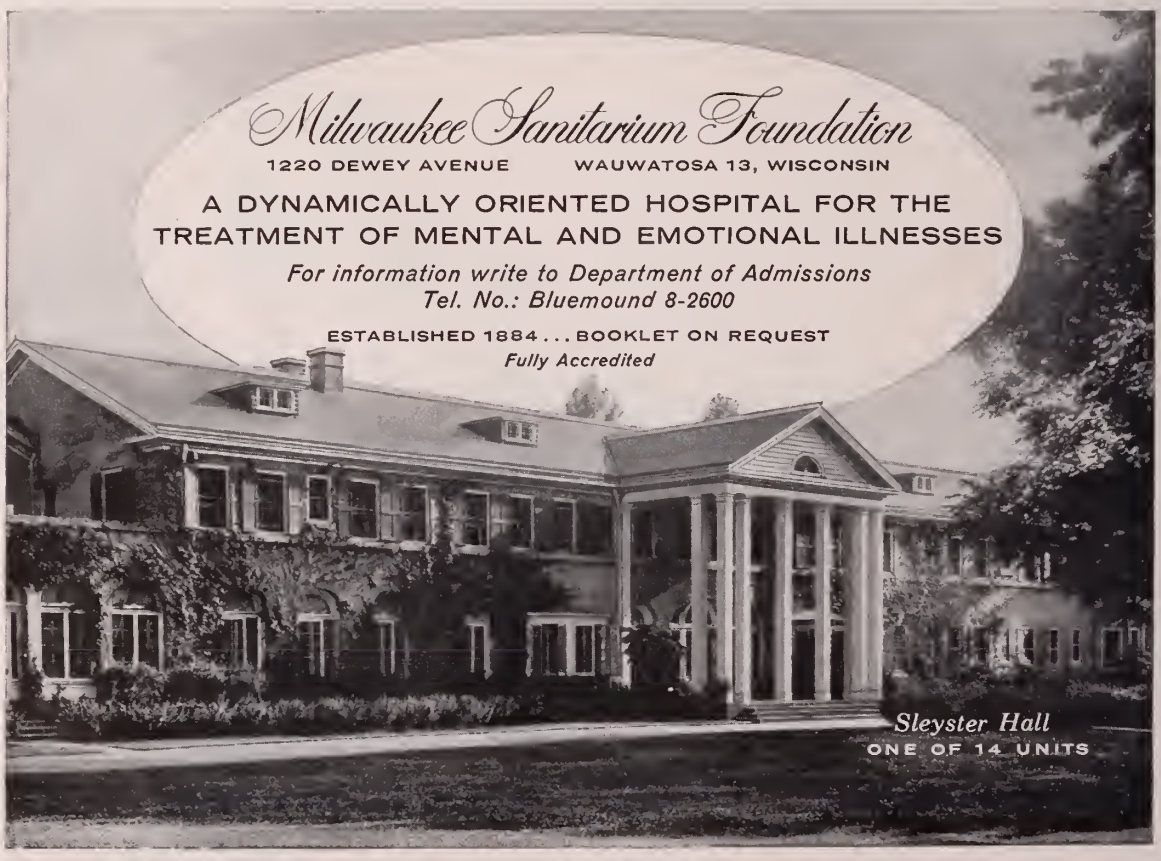
Dr. F. M. Schammel and *Dr. O. A. Hermundstad* have moved into their new clinic and office building in Stoughton.

Boscobel Hospital Staff Elects Officers

Newly elected officers of the medical staff at Memorial Hospital, Boscobel, are: *Dr. J. R. McNamee*, president; Dr. D. W. Dike, vice-president, and Dr. C. R. Moran, secretary.

Dr. Bessire Opens Madison Office

Dr. Milton C. Bessire, pediatrician, has opened medical offices in Madison. A graduate of the Baylor University College of Medicine, Doctor Bessire received pediatric training at the Children's Medical Center of Dallas, Tex. He was in private practice in Abilene, Tex., from 1948 to 1960 when he joined the staff of Central Wisconsin Colony and Training School at Madison.



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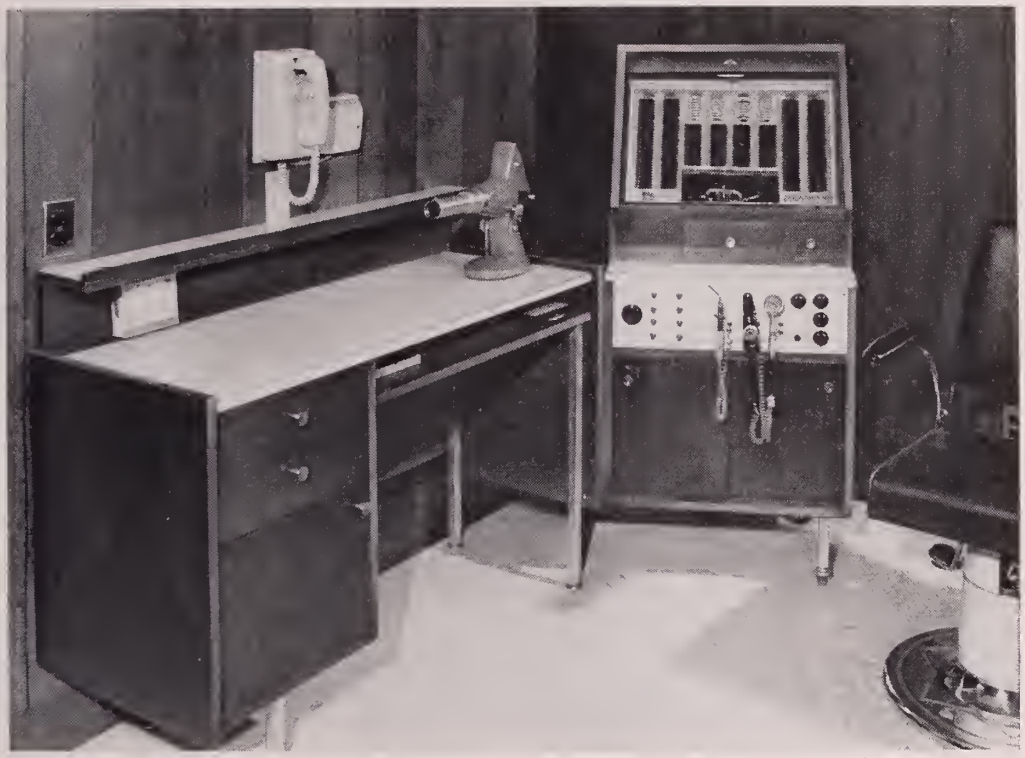

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WISCONSIN PHYSICIANS *continued*

Dr. Anderson Honored for Service

Dr. Henry A. Anderson, Stevens Point, was honored at a surprise dinner January 30 given by the Sisters of St. Joseph at River Pines Sanatorium. The event was in observance of his twentieth anniversary as medical director at the sanatorium.

Stevens Point Daily Journal Photo

Dr. Henry A. Anderson is shown with Herbert Weckmueller, Milwoukee, secretory of the Wisconsin Anti-Tuberculosis Association, ond Mrs. Anderson (left) ond Mrs. Corl N. Jacobs ond Mr. Jacobs, speoker of the evening, (right).

Dr. Stuessy Opens Platteville Office

Dr. Milton Stuessy has opened an office in the Medical Arts Building in Platteville. A 1954 graduate of the University of Wisconsin Medical School, he interned at South Bend, Ind., served in the Army Medical Corps, and practiced at Elkhorn, Dodgeville and Markesan.

Outstanding Work is Recognized

In recognition of his outstanding medical achievements, Dr. Jerome M. Maas, former Sheboygan resident, has been named a senior physician by Eli Lilly and Company. Associated with the pharmaceutical firm since 1947, Doctor Maas works in the clinical research division and is in charge of the clinical evaluation of new progestational and estrogen compounds. He conducts a clinic on endocrine problems at Marion County General Hospital in Indianapolis and has made important contributions to medical literature in the field of obstetrics and gynecology.

Belmont Physician Holds Open House

Dr. Cedric King, associated with the Cuba City Medical Center, held an open house Sunday, February 18, in the Belmont Medical building where he has recently set up practice.

Volunteers Hear Dr. Leonard Lieberman

Dr. Leonard Lieberman, medical director of the Milwaukee Mental Health Center, discussed the role of staff and volunteers in the care and rehabilitation of the aging patient at a meeting of volunteers sponsored by the Racine County Institutions and the Mental Health Association of Racine County February 19. The public program was held in the auditorium of the Mental Hospital at the institution.

Doctor Frackelton Presents Paper

Dr. William H. Frackelton, Milwaukee, presented a paper on "Neurovascular Island Pedicle Transfer Extension in Usage" at the January annual meeting of the American Society for Surgery of the Hand in Chicago.

Dr. McCormick Moves to Waukesha

Dr. G. L. McCormick, an ophthalmologist and otolaryngologist at the Marshfield Clinic for nearly 35 years, has become associated with *Drs. J. Victor Bolger* and *James V. Bolger, Jr.*, in Milwaukee and Waukesha. A native of Waukesha, Doctor McCormick interned at St. Joseph's Hospital in Marshfield and later did graduate work at the University of Illinois and in Vienna, Austria. Doctor McCormick and his wife will make their new home in Waukesha.

Friendship Physician Recognized Nationally

Dr. Arthur Weihe, Friendship, received the honor recently of being the subject of one of a series of feature articles entitled "Profile of an American," produced by the United States Information Agency for use in various publications all over the world. The November issue of the national Kiwanis Magazine also paid tribute to Doctor Weihe in an article dealing with "Rural America's Doctor Problem."

Mishicot Clinic Has Formal Opening

Formal opening of the Mishicot Clinic Building on Main Street took place Sunday afternoon, February 4. The building, which is now owned and occupied by *Dr. John E. Nilles* who has practiced medicine in the area for a number of years, was built as a project of the Mishicot Community Development Corporation.

Dr. Schmidt Begins Practice in Berlin

Dr. Erich M. Schmidt, Redgranite, has set up his practice in Berlin. Doctor Schmidt, who has practiced in the area for the past year, has been on the staffs of both the Wautoma and Berlin hospitals. Before coming to Redgranite, he was a practicing physician and surgeon in Winnipeg, Canada, for almost five years after coming to this continent as a refugee from behind the iron curtain. Born in West Prussia, Doctor Schmidt was a captain in the German Medical corps and served a four year tour of duty. He practiced an additional ten and one-half years behind the iron curtain in Germany and Poland after the war.

Clinic Takes in Doctor Conley

Dr. Harold L. Conley, who has been on the staff at Dells Clinic since 1960, has become associated with the clinic on a partnership basis. Doctor Conley came to Wisconsin Dells after completing his internship at Cook County Hospital, Chicago.

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WISCONSIN PHYSICIANS *continued*

Dr. Gregor Joins Waukesha County Clinic

Dr. Robert Gregor, formerly staff psychiatrist at Rogers Memorial Hospital, Oconomowoc, joined the staff of the Waukesha County Mental Health Clinic March 1 as a fulltime psychiatrist. Doctor Gregor was born at Macute, Yugoslavia, and studied medicine at the University of Zagreb in that country. He has been in the United States for the past four years and was licensed to practice medicine by the State Board of Medical Examiners.

Gillett Woman's Club Hears Dr. Klutzow

Dr. F. W. Klutzow, Gillett, was guest speaker at the monthly meeting of the Gillett Woman's Club February 1 in their club rooms.

N. P. Braun, M.D.

D. E. Dorchester, M.D.

Dr. N. P. Braun Joins Sheboygan Clinic

Dr. N. Peter Braun, specialist in orthopedic and hand surgery, has become associated with the staff of the Sheboygan Clinic. He was an orthopedic surgeon on the staff of The Monroe Clinic at Monroe before moving to Sheboygan.

The son of a Capetown, South Africa, dental surgeon, Doctor Braun attended the South African College School, the University of Capetown, and the Welsh National School of Medicine at Cardiff, Wales, where he received his medical degree in 1953. His internship was served at Cardiff Royal Infirmary and the Llandough Hospital. Later he became a resident in surgery at Cardiff Royal Infirmary where he also had a year in orthopedic training. He continued training in surgery and orthopedics at the Surbiton General Hospital in Surbiton, Surrey, England, and St. Margaret's Hospital in Epping, Essex, England.

Since coming to the United States in 1957, Doctor Braun has served as chief resident at the Lawrence Memorial Hospital in New London, Conn., and was in orthopedic residency at the University of Cincinnati General Hospital before becoming associated with The Monroe Clinic.

Hospital Staff Honors Dr. Nickels

Dr. A. C. Nickels, a Watertown physician since the 1930s, was guest of honor at a breakfast attended by some 30 physicians and surgeons February 8 at St. Mary's Hospital, Watertown. The breakfast was arranged by the sisters of the hospital. Doctor Nickels plans to leave Watertown in the near future to reside in Janesville.

Door County Auxiliary Hears Dr. Dorchester

Door County's flying doctor, *Dr. D. E. Dorchester* who often uses his plane to answer calls in the county, was guest speaker at the February meeting of the Door County Hospital Auxiliary February 5 at the C & C Club in Fish Creek. He showed the film, of the TV program, "M.D.—U.S.A.", on which he had appeared.

Doctor Rosekrans Flies to Colombia

Dr. Sarah Rosekrans, Niellsville physician and surgeon, flew to Colombia, South America, February 7 to attend the session of Pan American Medical Women's Alliance. Doctor Rosekrans served two years as president of the alliance and was chairman of the exhibits committee for this meeting. She was one of the founders of the alliance.

Dr. Epstein Elected to Board

Dr. Ely Epstein, Whitefish Bay, was elected to a three-year term on the board of the Milwaukee Psychiatric Service at the annual meeting held February 14 at the University Club in Milwaukee.

Safety Council Hears Dr. Hildebrand

Dr. William B. Hildebrand, Menasha, past president of the State Medical Society, spoke at the sixth meeting of the Twin City Safety Council's industrial division in Menasha February 21. His topic was "The Doctor's Role in Safety."

Dr. Dale H. Mann Opens Office

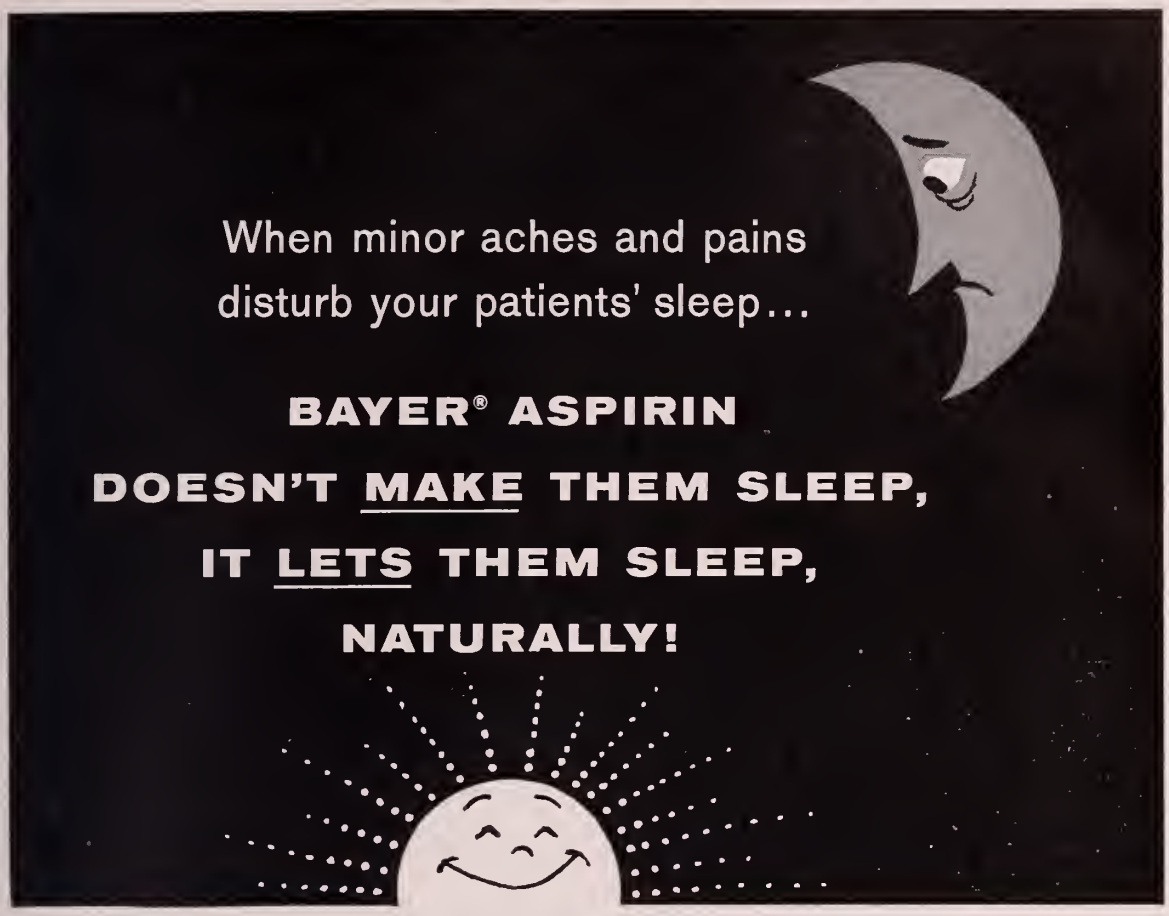
Dr. Dale H. Mann, pediatrician, has opened an office in Glendale. Following his graduation from the University of Wisconsin Medical School and his internship at Madison, he served two years in the Army at Fort Lewis, Wash. He completed his specialty in pediatrics at Milwaukee Children's Hospital.

Medical Center Opens at Stanley

Dr. J. J. LaBreche of Stanley and *Dr. D. A. Sallis* of Boyd have opened a new medical center, the La-Salle Medical Center, in Stanley.

Doctor Reese Speaks to Literary Club

Dr. Hans Reese, professor of neurology and psychiatry at the University of Wisconsin, spoke to more than 60 members of the Madison Literary Club at the University Club in Madison February 12. Doctor Reese, who spent six months in Egypt in 1961 and taught at the University of Alexandria, spoke on "Medical Lore in Ancient Egypt."



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WISCONSIN PHYSICIANS *continued*

On Program of Roentgen Ray Society

Dr. O. Arthur Stiennon and *Dr. James F. Land*, both of Madison, presented a paper on "Intra-aural Radiography of the Fenestra Ovale" at the annual meeting of the American Roentgen Ray Society held at the end of September, 1961, Miami Beach, Fla. The two radiologists explained refinement of a miniature x-ray film holder which they developed as an aid in planning ear surgery. The tiny film holder, much smaller than a dime, can be placed in the ear canal next to the eardrum to give a sharp picture of the condition of the middle ear.

Participants in Heart Association Meeting

Ten Wisconsin physicians participated in the annual meeting and scientific sessions of the American Heart Association held October 20–24, 1961, at Miami Beach, Fla. They are: *Drs. Richard H. Wasserburger, William P. Young, Betty J. Bamforth,* Lynn K. Hawkins, *Karl L. Siebecker, Jr.*, and Jay T. King, all of Madison, who presented "Epicardial Electrocardiographic Potentials in Congenital Heart Disease" and *Drs. Derward Lepley, Jr.*, William Bormes and Kenneth L. Kayser, all of Milwaukee, who discussed an electronic device for accurate identification of the cardiac conduction system and its use in open heart surgery, and *Dr. Francis F. Rosenbaum,* Milwaukee, who presented a paper he co-authored entitled "Pathophysiology of Heart Failure."

Dr. Banyai Authors Scientific Paper

Dr. Andrew L. Banyai, Chicago, was author of a paper published in the October, 1961, issue of *Archives of Environmental Health.* He stated in the article that "experimental and clinical observations attest to the serious implications of exposure to air pollutants currently found in our industrialized communities and in those with heavy motor vehicle traffic." Doctor Banyai is clinical professor of medicine, Emeritus, Marquette University School of Medicine, Milwaukee.

Dr. Gaynon Officer in Rhinologic Society

Dr. Irwin E. Gaynon, Milwaukee, has been named to the membership and education committee of the American Rhinologic Society for 1962. An introductory course on "Expanded Surgery of the Nasal Septum and Closely Related Structures" will be presented at the St. Michael Hospital, Milwaukee, May 16–19 with the cooperation of the ARS. Local committee consists of Drs. Irwin E. Gaynon, *Charles J. Finn* and *Frank G. Treskow.*

Dr. Jahn Elected to Thoracic Society Office

Dr. Richard P. Jahn, medical director of the Wisconsin Anti-Tuberculosis Association, was named president-elect of the Mississippi Valley Thoracic Society at its 1961 meeting in Chicago on October 13, 1961.

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Membership Report as of December 31, 1961

NEW MEMBERS

Kenneth R. Knutson, 731 Ethel Street, Wausau
Joseph E. Powell, Chetek.
Margaret M. Hanauer, 3542 North Hackett Avenue, Milwaukee 11.
Donald J. Taylor, 2710 Marshall Court, Madison.
David Shapiro, 325 North Appleton Street, Appleton.
Richard W. Edwards, Edwards Clinic, Richland Center.
Larry L. Hanley, Whitehall Clinic, Whitehall.
Thomas M. Kivlin, Oshkosh Clinic Building, Oshkosh.
John Haselow, 201 East Wisconsin Avenue, Neenah.
Thomas B. Davis, 687 Congress Place, Neenah.
Walter R. Hathaway, Theda Clark Hospital, Neenah.
John B. Hughes, 424 Washington Avenue, Oshkosh.

CHANGE OF ADDRESS

Richard L. Myers, to 1825 South Webster, Green Bay.
Murray Herman, to 229 South Main Street, Thiensville.
T. C. Puchner, to 425 East Wisconsin Avenue, Milwaukee 2.
Michael J. Kuhn, Jr., to 4284 North Raymir Place, Milwaukee 22.
Elizabeth A. Steffen, to 734 Lake Street, Racine.
Sydney M. Miller, to 3416 Blackhawk Drive, Madison 5.
Guy W. Carlson, to Zuelke Building, Suite 604, Appleton.
Bertram I. Milson, to 505 South Military Avenue, Green Bay.
Roger Laubenheimer, to 425 East Wisconsin Avenue, Milwaukee 2.
John R. Pellett, to 1426 East Skyline Drive, Madison 5.
P. M. Wilkinson, to Route 6, Box 588, Oconomowoc.
W. C. Rouman, Tomahawk, to 8736 West Palmetto Avenue, Milwaukee.
Harold J. Dvorak, New Jersey, to 2305 North Sherman Boulevard, Milwaukee 10.
G. P. Santos, Milwaukee, to 1429 West Packard Street, Appleton.
E. C. Ferguson, Juneau, to 9010 West Shorewood Drive, Apartment 418, Marcus Island, Washington.
J. D. McKenty, Marshfield, to Room 202, Colby-Abbott Building, 759 North Milwaukee Street, Milwaukee 2.
Robert J. Werra, Modesto, California, to 729 South Dora Street, Ukiah, California.
Christo Christoff, Germany, to 915 West Wisconsin Avenue, Milwaukee 3.
V. B. Hyslop, Brookfield, to 759 North Milwaukee Street, Milwaukee 2.
P. E. Millington, Milwaukee, to 1005 Madera Circle, Elm Grove.
Leo V. Kempton, Villa Park, Illinois, to 135 South Kenilworth Avenue, Elmhurst, Illinois.
Capt. Robert L. Bolton, Milwaukee, to 829th Medical Group, Larson AFB, Washington.
J. R. Fowler, Waterloo, to 14 Eastern Avenue, Pleasantville, New York.

Membership Report as of January 31, 1962

NEW MEMBERS

Dean D. Miller, V.A. Hospital, Wood.
Richard L. Morgan, Columbia Hospital, Milwaukee.
Archie Pequet, 2212 West State Street, Milwaukee.
Robert F. Lipo, 4209 Market Drive, Tumwater, Washington.
Carol M. Franklin, V.A. Hospital, Wood.
Roland G. Evenson, St. Luke's Hospital, Milwaukee.
Barbara W. Thompson, 5456 North Lydell Street, Milwaukee.
Viggo B. Olsen, c/o A.B.W.E., 1505 Race Street, Philadelphia 2, Pennsylvania.
Allen J. Savitt, 7635 West Oklahoma Avenue, Milwaukee.
Myron N. Lovett, 1672 South 9th Street, Milwaukee.
Ildefonso L. Asinas, 5757 South 108th Street, Hales Corners.
Leonard B. Kleinerman, Milwaukee County Hospital, Milwaukee 13.
Helen M. Worsencroft, 324 East Wisconsin Avenue, Milwaukee.
Desmond P. McNelis, Milwaukee Sanitarium, Wauwatosa.
Kenneth O. Johnson, 1513 East Capitol Drive, Milwaukee.
Robert B. Fruchtman, Milwaukee County Hospital, Milwaukee.
Philip P. Cohen, University of Wisconsin, 1300 University Avenue, Madison 6.
J. J. Ferrari, 430 South Webster Avenue, Green Bay.
Ernesto F. Sabado, Mercy Hospital, Janesville.
Clarence A. Klasinski, 431 East Mt. Morris, Wautoma.
Gloria E. Sarto, 2317 Fish Hatchery Road, Madison.

CHANGES OF ADDRESS

Arthur A. Rand, Mayfair Professional Building, 2500 North 108th Street, Milwaukee 13.
Frank P. Falsetti, 6001 West Center Street, Milwaukee.

SOCIETY RECORDS *continued*

Harold H. Oberfeld, 908 Milwaukee Avenue, South Milwaukee.

Eugene L. Dalwig, 4704 West Wisconsin Avenue, Milwaukee.

G. Richard Keskey, 5123 North Prospect Avenue, Milwaukee.

Walter Schwartz, 2212 West State Street, Wauwatosa.

James M. Sorenson, 1714 East Capitol Drive, Milwaukee.

Charles L. Weisenthal, 606 West Wisconsin Avenue, Milwaukee.

George R. Wagner, 8125A Oklahoma Avenue, Milwaukee.

Richard L. Wiesen, 2761 South 60th Street, Milwaukee.

M. S. Freedman, 1212 West Wisconsin Avenue, Milwaukee 3.

G. H. Handy, P. O. Box 827, Wisconsin Rapids.

A. M. Lucas, P. O. Box 827, Wisconsin Rapids.

A. H. Heidner, P. O. Box 42, West Bend.

G. F. Denys, 700 East Walnut Street, Green Bay.

S. B. Gundersen, Route 1, West Salem.

K. L. German, P. O. Box 254, Eau Claire.

V. V. Quandt, P. O. Box 26, Hartford.

J. G. Hoffman, P. O. Box 138, Hartford.

Leander J. Van Hecke, 6001 West Center Street, Milwaukee.

Morton F. Phillips, 1531 East Fairmont Avenue, Milwaukee.

Frank L. Ziehl, 6001 West Center Street, Milwaukee

Angelo C. Alexander, 312 Seventh Street, Racine.

R. E. Garrison, P. O. Box 827, Wisconsin Rapids.

A. W. Hulme, P. O. Box 827, Wisconsin Rapids.

J. H. Steiner, 208 East Union Street, Waupaca.

R. L. Cowles, 305 East Walnut Street, Green Bay.

J. J. Sazama, 133 West Central Avenue, Chippewa Falls.

F. B. Sazama, 133 West Central Avenue, Chippewa Falls.

A. L. Mayfield, 318–71st Street, Kenosha.

F. W. Sachse, P. O. Box 199, Hartford.

W. J. Petters, 200 East Main, Waupun.

M. E. Monroe, P. O. Box 146, Hartford.

J. L. Algiers, P. O. Box 110, Hartford.

L. B. Perssion, 1725 East Kane, Milwaukee 2.

Frederick P. Krumenacher, 6930 North Beech Tree Road, Milwaukee 9.

E. A. McKenna, P. O. Box 340, Antigo.

D. R. Notbohm, 411 Madison Avenue, Fort Atkinson.

Harlan Levin, 1 South Main Street, Janesville.

P. J. Finucane, 1620 Ohm Avenue, Eau Claire.

Frank Balistreri, 7481 North Seneca, Milwaukee 17.

James H. Schultz, P. O. Box 42, West Bend.

W. A. Nielsen, P. O. Box 42, West Bend.

B. F. Rahn, Route 4, Box 95, Chippewa Falls.

Paul M. Cunningham, 228 West College Avenue, Appleton.

C. W. Crawford, 720 Marquette Avenue, Green Bay.

H. E. Thimke, R-22 Patton Street, Eau Claire.

E. A. Stika, 211–9th Street, Racine.

R. W. Cromer, P. O. Box 280, Antigo.

John A. Szweda, 108 North Lincoln, Beaver Dam.

G. G. Giffen, 605 Walker Avenue, Eau Claire.

J. A. Booher, Route 3, Reedsburg.

K. E. Walter, 1620 Ohm Avenue, Eau Claire.

Haydon R. Duffy, 6911 North Glen Shore, Milwaukee.

James F. Baumgartner, P. O. Box 42, West Bend.

R. H. Driessel, P. O. Box 42, West Bend.

W. C. Henske, 100½ North Bridge Street, Chippewa Falls.

D. M. Mehigan, 3622 West Silver Spring Drive, Milwaukee.

W. H. Bennett, 524 Main Street, Racine.

Arthur J. Jacobsen, 3335 Taylor Avenue, Racine.

C. F. Ulrich, 525–69th Street, Kenosha.

W. A. Hilger, 3070 North 87th Street, Milwaukee 10.

Ruth E. Church, Walworth, to Medical Director, Waukesha County Health Department, Court House, Waukesha.

Nunilo L. Bugarin, Milwaukee, to 327 Wisconsin Avenue, Tomahawk.

Theodore W. Dasler, Milwaukee, to 650 South Central Avenue, Marshfield.

Nola M. Moore, Sedro Wooley, Washington, to 6190 NE 187th Street, Seattle 55, Washington.

George N. Spencer, Wood, to 926 Milwaukee Avenue, South Milwaukee.

William J. Von Ruden, Shawano, to 563–37th Street, Apartment 1, San Francisco 21, California.

L. O. Langer, Jr., Madison, to 1230 North Queen Street, Minneapolis, Minnesota.

Edwin L. Bemis, West Allis, to 620 North 19th Street, Milwaukee 3.

M. F. Stuessy, Elkhorn, to 329 East Main Street, Platteville.

Marvin G. Jumes, Sheboygan, to 9112 B. Utah Drive, Fairchild Air Force Base, Spokane, Washington.

S. P. Vinograd, Washington, D. C., to 11908 Old Bridge Road, Rockville, Maryland.

D. J. Cohen, Great Lakes, Illinois, to 2411 West Capitol Drive, Milwaukee 6.

W. S. Boutwell, Janesville, to 917 East Michigan, Wheaton, Illinois.

Richard L. Weisen, Wood, to 2761 South 60th Street, Milwaukee 19.

R. N. Burch, Oconomowoc, to 237 Wisconsin Avenue, Waukesha.

J. J. O'Hara, Milwaukee, to Box 31, Oconomowoc.

*Mitchell A. Rapkin, Madison, to 105 Kiernan Drive, Rantoul, Illinois.

---

* Military member.

Medical Meetings
Postgraduate Courses

Wisconsin Postgraduate Courses

The University of Wisconsin Medical Center will present the following postgraduate courses at Madison during April:

Recent Advances in Management of Problem Labors—Room 426, University Hospital, April 12

A $10 registration fee is to be paid at the time of application. The fee includes instruction, materials, and coffee and refreshments served at mid-afternoon.

Psychophysiology in Medicine, Wisconsin Center, April 26–28

Tuition is $50 and includes materials, coffee breaks, any necessary chartered transportation, and noon lunches.

Further information on either course may be obtained by writing the Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

American College of Physicians

The following postgraduate courses will be presented throughout the country by the American College of Physicians:

Fundamental and Applied Aspects of Cardiology, Wayne State University College of Medicine, Detroit, Michigan, May 14–16.

The Neurology of Diseases of Internal Medicine, Harvard Medical School, Boston, Massachusetts, May 21–25.

Psychiatry for the Internist, The Psychiatric Institute, University of Maryland School of Medicine, Baltimore, Maryland, June 4–8.

Further information may be obtained by writing the Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania.

American Cancer Society

The 1962 Scientific Session of the American Cancer Society is scheduled for October 22 and 23 at the Biltmore Hotel, New York City, New York. Theme for the 1962 session will be "The Clinical Impact of a Quarter Century of Cancer Research."

This meeting will celebrate Cancer Progress Year since 1962 is the 25th anniversary of the National Cancer Institute. There will be outstanding papers by leading scientists in America on the Causation of Cancer, Biological Aspects of Cancer, Detection and Diagnosis of Cancer and Therapy of Cancer.

For further information, contact the Director of Professional Education, American Cancer Society, 521 West 57th Street, New York 19, New York.

A.M.A. Council on Rural Health

The Council on Rural Health of the American Medical Association will hold its third regional rural health conference in Des Moines, Iowa, May 18–19.

Medical Library Association

The 61st annual meeting of the Medical Library Association will be held in Chicago June 4–8 at the Sheraton-Chicago Hotel. Further information may be obtained by writing the Medical Library Association, 919 N. Michigan Avenue, Chicago 11, Illinois.

Upper Peninsula of Michigan Medical Society

The Upper Peninsula of Michigan Medical Society will hold its annual meeting at the Gateway Hotel, Land O'Lakes, Wisconsin, June 15–17. The first two days will be devoted to a variety of timely medical subjects embracing the whole field. The third day's meeting will be conducted by the Lederle Laboratories. A ladies' program also is being planned.

Chest Physicians Postgraduate Courses

The Council of Postgraduate Medical Education of the American College of Chest Physicians has planned the following five postgraduate courses to be held during 1962:

Cardiopulmonary Problems in Children, Chicago, Illinois, Edgewater Beach Hotel, July 23–27

Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Warwick Hotel, Philadelphia, Pa., Sept. 17–21

Clinical Cardiopulmonary Physiology, Knickerbocker Hotel, Chicago, Ill., October 22–26

Recent Advances in the Diagnosis and Treatment of Diseases of the Heart and Lungs, Barbizon-Plaza Hotel, New York, Nov. 12–16

Occupational Diseases of the Heart and Lungs, Statler-Hilton Hotel, Detroit, Mich., December 3–7

Tuition for each course is $75 for members of the American College of Chest Physicians and $100 for nonmembers.

Additional information may be obtained by writing to Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

WISCONSIN CALENDAR COMING EVENTS

1962

Apr. 11: Conference on "Care of the Premature Infant," Appleton Memorial Hospital, Appleton.

Apr. 12: Half-day course in gynecology—obstetrics, UW, University Hospital, Madison.

Apr. 12–14: Psychiatry in Hospitals, an institute for psychiatrists, administrators, medical directors, nursing supervisors, psychologists, social workers and therapists; Conrad Hilton Hotel, Chicago, sponsored by Catholic Hospital Association.

Apr. 18: Conference on "Care of the Premature Infant," St. Joseph's Hospital, Dodgeville.

Apr. 25: Conference on "Care of the Premature Infant," Park Falls Memorial Hospital, Park Falls.

Apr. 26: Conference on "Care of the Premature Infant," Rice Lake High School, Rice Lake.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 3: Half-day course in therapeutics, UW, University Hospital, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

May 18–19: Third regional Rural Health Conference of AMA at Des Moines, Ia.

June 19–20: Annual meeting of Wisconsin Association of Public Health, Madison.

June 24–28: AMA Annual Meeting, Chicago, Illinois.

July 27–28: SMS Council Meeting, Land o'Lakes.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

MEDICAL MEETINGS *continued*

Chest Physicians Meetings

The following major meetings have been scheduled for the American College of Chest Physicians:

28th Annual Meeting, Morrison Hotel, Chicago, Ill., June 21–25, 1962.

Interim Session, Ambassador Hotel, Los Angeles, Calif., Nov. 24–25, 1962.

Seventh International Congress on Diseases of the Chest, New Delhi, India, Feb. 20–24, 1963.

Postgraduate Course in Pediatrics

The Fifth Annual Postgraduate Course in Pediatrics, covering Clinical and Research Advances in Pediatrics and Child Guidance Problems, will be presented by the Department of Pediatrics and the Office of Postgraduate Medical Education of the University of Colorado School of Medicine August 6 through August 10 at the Stanley Hotel in Estes Park, Colorado.

Tuition fee for the five-day course is $75 (including a nonrefundable registration fee of $10). The University reserves the right to limit registration, with preference being given to those registering for the entire course.

While the Stanley Hotel is the headquarters for the meeting, a great variety of other types of accommodations are available in the Estes Park area, and detailed information may be secured by writing to the Chamber of Commerce, Estes Park, Colorado.

International Dermatology Congress

For the first time in 55 years, the United States will be the setting for the International Congress of Dermatology. Sponsoring the XII International Congress of Dermatology, which will meet in Washington, D. C., Sept. 9 to Sept. 15, will be the American Academy of Dermatology with co-sponsors composed of the American Dermatological Association, the A.M.A. Section on Dermatology, the Society for Investigative Dermatology and the Canadian Dermatological Association. Specialists in dermatology from 37 countries are expected to participate.

According to Dr. Donald M. Pillsbury, Philadelphia, Pa., congress president, the scientific program will be one of the most extensive ever presented in one special field of medicine. Sixteen symposiums will apply advances in basic sciences to clinical dermatology.

Activities, which will be concentrated at the Shoreham and Sheraton Park Hotels, also will include special social and cultural functions and a program of women's events.

the Wisconsin Medical Journal

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VOL. 61, NO. 4—APRIL 1962

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MEDICAL STAFF

William L. Herner, M. D., Medical Director
John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Richard O. Barnes, M. D.
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County Society Proceedings

DANE

Dr. Thomas Meyer, department of pediatrics, University Hospitals, Madison, spoke on "Medical Experiences in South Africa" at the regular meeting of the Dane County Medical Society March 13 at the State Medical Society Building.

DOOR-KEWAUNEE

Sixteen members of the Door–Kewaunee County Medical Society met at Hotel Stebbins in Algoma February 27 to hear Dr. A. Friedman speak on orthopedics in Viet Nam. *Dr. H. J. Kief*, sixth district councilor, relayed the results of the last two caucus meetings.

DOUGLAS

Theodore H. Rowell, chairman of the board of directors of Rowell Laboratories, Baudette, Minnesota, was the guest speaker at the Douglas County Medical Society meeting March 7 at Hotel Superior in Superior. A native of Beaver Dam, Mr. Rowell organized the Baudette firm in 1935 and has guided Rowell Laboratories for the past 25 years. He spoke on the problems and cost of marketing new prescription drugs.

EAU CLAIRE-DUNN-PEPIN

The Tri-County Medical Society of Eau Claire–Dunn–Pepin at their monthly meeting on February 26 voted to support the contention of the Menomonie Memorial Hospital staff that chiropractic treatments for workmen's compensation cases should neither be authorized nor paid for from public funds. A committee of four Dunn County physicians was appointed to investigate the matter further and to engage legal counsel in an effort to prevent further misuse of tax funds.

GRANT

Members of the Grant County Medical Society heard *Dr. Fred J. Ansfield*, Madison, speak on the role of the family physician in chemotherapy of disseminated cancer February 22 at Lancaster. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

GREEN LAKE-WAUSHARA

Dr. C. W. Crumpton, Madison, associate professor, department of medicine, University of Wisconsin, spoke on "Hypertension" at The Green Lake–Waushara County Medical Society meeting in Wautoma February 22.

Physicians whose names appear in italic are members of the State Medical Society.

His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Heart Association.

MILWAUKEE

Representatives of 11 voluntary health agencies met Feb. 14 with members of The Medical Society of Milwaukee County, Milwaukee Association of Commerce, Greater Milwaukee Committee, Milwaukee Labor Council AFL-CIO, and the Better Business Bureau to discuss plans for combined fund raising. The meeting, which was held in the county medical society offices, was called by the Milwaukee medical society to bring together interested persons to discuss the proposed Combined Health Agencies of Milwaukee Plan (CHAMP) which has been adopted in principle by six of the agencies.

Agencies which have accepted the principle of CHAMP are: American Cancer Society—Milwaukee Division; Easter Seal Society of Milwaukee County; Arthritis and Rheumatism Foundation—Wisconsin Chapter; United Cerebral Palsy of Milwaukee, Inc.; Muscular Dystrophy Association of America—Metropolitan Milwaukee Chapter; and United Association of Retarded Children. Other organizations represented at the meeting were: National Society for the Prevention of Blindness; Wisconsin Heart Association; Milwaukee County Association for Mental Health; and Multiple Sclerosis Society of Milwaukee, Inc.

RICHLAND

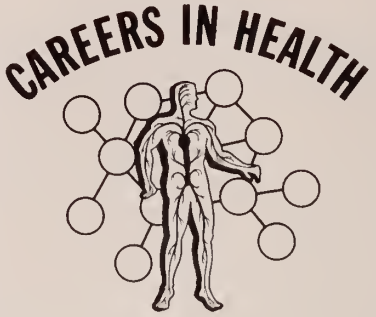
The Richland County Medical Society met in the Richland Hospital library in Richland Center March 1 to hear *Dr. Paul Davidson*, Madison, speak on liver diseases. Other Madison guests were *Dr. William Ylitalo* and *Dr. A. D. Anderson*.

PIERCE-ST. CROIX

The Pierce-St. Croix County Medical Society met March 20 at the JR Ranch, east of Hudson.

SAUK

The Sauk County Medical Society met at the Warren Hotel in Baraboo March 13 to hear *Dr. Samuel Harper*, Madison, speak on "A typical Papanicolaou Smear."



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SHEBOYGAN

Possibility of establishing a cytology laboratory in Sheboygan was discussed at the February meeting of the Sheboygan County Medical Society held at Pine Hills Country Club. No action was taken on the proposal. Unanimous approval was given to a resolution urging all people of Sheboygan County, of all ages, to obtain tetanus toxoid inoculations, and to obtain booster shots as recommended by private physicians. A committee was named to prepare a memorial for Dr. Alfred C. Radloff, one of the society's two life members, who died February 22.

The society sent two of its members to the Third Annual Convention for Officers of Component County Medical Societies held March 16 in Chicago.

TREMPEALEAU-JACKSON-BUFFALO

Twelve members of the Trempealeau-Jackson-Buffalo County Medical Society met at Club Midway in Independence January 23 to hear *Dr. Ralph F. Hudson,* Eau Claire, speak on internal injuries of the abdomen.

WINNEBAGO

The Winnebago County Medical Society met March 1 at the Athearn Hotel, Oshkosh. Guest speaker was *Dr. F. J. Hofmeister,* Milwaukee, who talked on "Practical Problems Concerning Ovarian Tumors."

WOOD

Mr. Jack Ryon, American Medical Association field representative, discussed the King-Anderson Bill with 45 members of the Wood County Medical Society at Hotel Charles in Marshfield March 1.

MEDICAL LIBRARY ASSOCIATION HEADQUARTERS

The Medical Library Association has opened a headquarters office in Chicago and appointed an executive secretary to coordinate the work of the association. Mrs. Helen Brown Schmidt, formerly Assistant Director of the Midwest Inter-Library Center in Chicago, has been named Executive Secretary. The new office is located at 919 N. Michigan Avenue, Chicago 11, Ill.

Miss Helen Crawford, librarian of the University of Wisconsin Medical School Library, is a member of the Board of Directors.

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*As You Like It, Act II, Sc. 7

Specialty Society Proceedings

Wisconsin Psychiatric Association

Officers of the Wisconsin Psychiatric Association elected at the March 3 meeting at Three Lakes are as follows:

President: *Dr. Charles Landis,* Milwaukee
President-elect: *Dr. Keith Keane,* Appleton
Secretary: *Dr. Carroll Osgood,* Wauwatosa
Treasurer: *Dr. Robert E. O'Connor,* Madison
Council Members-at-large: *Dr. Albert Lorenz,* Eau Claire and *Dr. B. Cullen Burris,* Wauwatosa.

Milwaukee Oto-Ophthalmic Society

The Milwaukee Oto-Ophthalmic Society met March 27 at the University Club in Milwaukee. Ray H. Barsch, Ph.D., director of the child development division, Easter Seal Society of Milwaukee County, spoke on "The Space World of Vision and Audition."

Wisconsin Academy of General Practice
Southwest Chapter

Members of the Southwest Chapter of the Wisconsin Academy of General Practice began a series of six refresher course meetings March 20 at St. Joseph's Hospital in Iowa county. University of Wisconsin instructors will conduct the sessions on Tuesday nights.

Physicians whose names appear in italic are members of the State Medical Society.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine met March 20 at the University Club in Milwaukee to hear Dr. Eugene F. Poutasse, Cleveland Clinic, speak on "Surgical Correction of Renal Hypertension."

Wisconsin Academy of General Practice
Dairyland Chapter

An organizational meeting of the Dairyland Chapter of the Wisconsin Academy of General Practice was held at the Hotel Charles in Marshfield March 22. Acting as president pro tem was *Dr. Raymond L. Hansen,* Colby, and as secretary pro tem, *Dr. Elizabeth Baldwin,* Marshfield. *Dr. A. H. Stahmer,* Wausau, president of the state organization, presented the charter to the new chapter which is comprised of members from Taylor, Clark, western Marathon and north Wood counties.

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children (5 to 12 years), from 50 to 100 mg. three or four times daily.

Before prescribing, consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

References: 1. DeNyse, D. L.: M. Times *87*:1512 (Nov.) 1959.
2. Gruenberg, F.: Current Therap. Res. *2*:1 (Jan.) 1960.

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News of Wisconsin Physicians

Doctor Pitot Gets Lederle Award

Dr. Henry C. Pitot III, Madison, has received a Lederle Medical Faculty Award of $30,000 for partial salary support over a three-year period. He is assistant professor of oncology and pathology at the University of Wisconsin Medical School and also is doing cancer research. He is a diplomate of the American Board of Pathology.

Dr. Springer Renamed Chief of Staff

Dr. D. W. Springer, Monroe, was renamed chief of the medical staff of St. Clare hospital February 19. Other officers reelected for their second term were *Dr. M. W. Stuessy,* Brodhead, vice-chairman, and *Dr. R. F. Wichser,* Monroe, secretary.

Doctor Fox Talks on Heart Disease

Dr. James Fox, La Crosse, told the La Crosse Exchange Club March 1 that principal causes of coronary heart disease are improper diet, lack of exercise and heavy smoking. He pointed out that current studies show a correlation based on heredity and emotional make-up, while race makes no difference. Women tend to have fewer attacks than men, he stated.

Dr. Fisher Resigns Sparta Post

Dr. Albert L. Fisher, La Crosse psychiatrist and neurologist, has resigned as consultant at the Wisconsin Child Center, Sparta, in order to devote full time to his private practice in La Crosse. He also is a part-time consultant to the La Crosse County Child Guidance Clinic in La Crosse.

Dr. Andrews Tells of African Trip

Dr. George R. Andrews, Wausau, spoke on his recent travels to Africa before members of the American Lutheran Church of First English Lutheran Church in Wausau March 1. He showed slides taken during a week he spent with Dr. Albert Schweitzer at his hospital in Africa.

Altrusans Hear Doctor Arndt

Dr. George W. Arndt, medical director of the Winnebago County Guidance Center, addressed the Neenah-Menasha Altrusa Club at the Valley Inn in Neenah February 28. He spoke on the service of the Guidance Center which is jointly sponsored by the county board and Winnebago County Guidance Center, Inc.

Dr. Zeit Speaks at Hospital Dedication

Dr. Walter Zeit of Marquette University, Milwaukee, formerly of Medford, was guest speaker at the dedication ceremonies March 3 of the new Memorial Hospital of Taylor County. His topic was "Relationship of the Hospital and the Community."

Dr. Samp to Remain at University

Dr. Robert J. Samp, Madison, will stay on as assistant surgery professor at the University of Wisconsin Medical School it has been confirmed by Dr. Philip P. Cohen, acting dean of the medical school. Doctor Samp, a frequent speaker to groups interested in cancer education, had considered an offer by the Papanicolaou Cancer Institute, Miami, Fla., to help coordinate the institute's work and conduct cancer education.

Dr. Eyvindsson Joins Hospital Staff

Dr. Elias T. Eyvindsson, Winter, has opened private practice in the office of *Dr. J. L. Murphy,* Park Falls. The addition of Doctor Eyvindsson brings the medical staff at Park Falls Memorial Hospital to a total of seven.

A native of Iceland, Doctor Eyvindsson is a graduate of the University of Iceland Medical School and served a special internship at the Wisconsin General Hospital in Madison. He spent six months with a clinic in Eau Claire and had a fellowship at Mayo Clinic in Rochester, Minn. He also took postgraduate work in surgery at the University of Iceland. He has been practicing for 18 years, and for the past several years has been employed by the government of Iceland as medical director of a 40-bed hospital in Neskaupstad.

Dr. Bartley Speaks to Rotarians

Dr. Vernon Bartley, Eagle River, spoke on "Socialized Medicine" before the Rotary Club of Eagle River March 5.

Milwaukee Physician Joins Berlin Clinic

Dr. Kenneth P. Schroeder, Milwaukee, will join *Dr. L. J. Seward's* clinic in Berlin July 1, it has been announced by Doctor Seward.

Dr. Mann Opens Milwaukee Office

Dr. Dale H. Mann, formerly of Fond du Lac, has opened an office for the practice of pediatrics in Milwaukee. He is a graduate of St. Mary's Springs Academy and the University of Wisconsin Medical School. He recently completed a two-year residency in pediatrics at Milwaukee Children's Hospital.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Klein Opens Platteville Office

Dr. G. J. Klein, Hazel Green, has opened an office in the State Bank building in Platteville to facilitate the practice of surgery. He will continue his surgical work and general practice in Hazel Green, and will be in his office at Platteville Tuesday and Friday afternoons.

La Crosse Tribune Photo by Frances E. Burgess

Dr. Alfhild Jensen, La Crosse, is shown with an anesthesia machine like the one she shipped to Formosa as a gift.

Formosa Mission Receives Help

Fulfilling a dream of helping little children, *Dr. Alfhild Jensen*, La Crosse anesthesiologist, left March 16 for a six-month self-made mission assignment in Formosa. She will work in two hospitals of the Norwegian Missionary Alliance of the Lutheran Church, contributing equipment that she purchased especially for the work; paying her own way to Formosa and back; working without salary; and paying her own living expenses during the entire six months.

An anesthesia machine, equipped with the most modern devices in the specialized field, is the most important part of her gift to the mission hospitals in Taipei and Pingtung, but she also took anesthetics, medicines and related supplies totalling some 700 pounds.

The mission in which she is serving is headed by Dr. Kristoffer Fotland of Norway whose mission service in the Orient dates back to 1938. She had been informed that there is much major surgery to be done, but the well qualified orthopedic surgeon and chest surgeon on the staff could not do surgery without modern anesthesia equipment.

Doctor Jensen's address is Christian Clinic and Children's Sanatorium, 183 Chung Hua La, Pingtung, Taiwan, Republic of China.

Dr. Roemhild to Watertown

Dr. Franklin N. Roemhild is moving about April 1 from Prairie Farm, a rural community in Barron County, to Watertown where he will take over the offices and practice of Dr. A. C. Nickels who is planning to retire. Doctor Roemhild, a native of Aurora, Ill., received his M. D. degree from the University of Illinois in 1949, interned at University Hospitals in Madison, and has been practicing medicine since 1950.

Dr. Samp Speaks at Sports Banquet

Dr. Robert J. Samp, University Hospitals, Madison, spoke on "Athletics and Your Health" at the annual Jefferson all-sports banquet held in the senior high school gymnasium March 22. Doctor Samp has addressed over 1,600 audiences in 400 cities in 40 states.

Tomah Hospital Has New Director

The Area Medical Office of the Veterans Administration at St. Paul, Minnesota, has named Dr. Frederick J. Bradshaw, Jr., Acting Director of the Tomah Veterans Administration Hospital upon the departure of Dr. T. E. Dredge who is transferring to the Veterans Administration Hospital, Minneapolis, Minnesota. Doctor Bradshaw has been chief of the professional staff at the Tomah Hospital since Feb. 23, 1958. Prior to that he served at veterans hospitals at Ft. Meade, South Dakota; Palo Alto, California; St. Cloud, Minnesota; Coatesville, Pennsylvania, and Gulfport, Mississippi. During World War II he served with the U. S. Army as chief of the Neuropsychiatric Service at Barnes General Hospital, Vancouver, Washington, and the 69th General Hospital in India.

Preventive Medicine Discussed

Dr. John Krohn, Black River Falls, presented a program on what is new in preventive medicine before the American Home Department of the Black River Falls Woman's Club February 28 at the home of Mrs. Mary McDonald.

Milwaukee Hospital Elects Officers

Dr. James O'Connell, Milwaukee was elected president of the medical staff of St. Francis Hospital in Milwaukee at the staff's annual meeting recently.

Dr. Stanley Korducki, Milwaukee, was elected vice-president and Dr. Kenneth J. Stollenwerk, Milwaukee, was reelected secretary-treasurer.

Dr. Turrell Will Speak to Psychiatrists

Dr. Eugene S. Turrell, professor and chairman of the Department of Psychiatry, Marquette University School of Medicine, will be a speaker at the Psychiatry in Hospitals institute for psychiatrists, administrators, medical directors, nursing supervisors, psychologists, social workers and therapists to be held at the Conrad Hilton Hotel, Chicago, April 12–14. The institute will be sponsored by the Catholic Hospital Association.

Dr. Egan on National Committee

Dr. Gregory J. Egan, Jr., La Crosse, has accepted appointment for the second year as a member of the scholarship committee for Wisconsin of The National Foundation for Medical Scientific Research, Professional Education and Medical Care.

Dr. Allin Gives Care of Aged Talks

Dr. Robin Allin, Madison, has spoken before several groups on "Health Care of the Aged." He spoke to the Lions Club in Stoughton February 26, and to the Fond du Lac County Medical Society and the Fond du Lac County Medical Auxiliary February 22.

Internists on National Committees

Two Wisconsin internists are serving on committees of the American Society of Internal Medicine which will hold its Sixth Annual Meeting April 6–8 at the Benjamin Franklin Hotel in Philadelphia, Pennsylvania. They are *Dr. Leslie G. Kindschi,* Monroe, member of the medical services committee, and *Dr. Robert L. Gilbert,* La Crosse, member of the subcommittee on forms and the membership committee.

Dr. Schulz Joins Shawano Clinic

Dr. Don W. Schulz, a native of Colby, has joined *Dr. H. C. Marsh* and *Dr. W. A. Coan* at the Marsh Clinic at Shawano. Doctor Schulz came to Shawano from Pennsylvania where he spent the past two years at Valley Forge General Hospital. He received his M.D. degree from the University of Wisconsin Medical School in 1956. He spent one year as an Army intern at Letterman General Hospital in California and attended the Army Medical Field Service school at San Antonio, Tex., for six months. He took a general practice residency at Ft. Knox, Ky., before going to Pennsylvania.

Rotary Club Hears Doctor Szweda

Dr. John Szweda of Beaver Dam discussed heart problems before the Waupun Rotary Club February 13.

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A family of obesity-control aids combining appetite control and nutritional supplementation. Four dosage forms from which to choose; each containing dextroamphetamine with a barbiturate to prevent excessive central stimulation, and vitamins to supplement the restricted diet:

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Phenobarbital	16 mg.	32 mg.	....
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Vitamin C	100 mg.	100 mg.	15 mg.
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Niacinamide	20 mg.	20 mg.	3 mg.
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More than twice as potent as prednisolone, Alphadrol exhibits no new or bizarre side effects. Salt retention, edema or hypertension, potassium loss, anorexia, muscle weakness or muscle wasting, excessive appetite, abdominal cramping, or increased abdominal girth have not been a problem.

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The benefits of Alphadrol (anti-inflammatory, antiallergic, antirheumatic, antileukemic, antihemolytic) are indicated in acute rheumatic carditis, rheumatoid arthritis, asthma, hay fever and allergic disorders, dermatoses, blood dyscrasias, and ocular inflammatory disease involving the posterior segment.

Precautions and contraindications
Patients on Alphadrol will usually experience dramatic relief without developing such possible steroid side effects as gastrointestinal intolerance, weight gain or weight loss, edema, hypertension, acne or emotional imbalance.

As in all corticotherapy, however, there are certain precautions to be observed. The presence of diabetes, osteoporosis, chronic psychotic reactions, predisposition to thrombophlebitis, hypertension, congestive heart failure, renal insufficiency, or active tuberculosis necessitates careful control in the use of steroids. Like all corticosteroids, Alphadrol is contraindicated in patients with arrested tuberculosis, peptic ulcer, acute psychoses, Cushing's syndrome, herpes simplex keratitis, vaccinia, or varicella.

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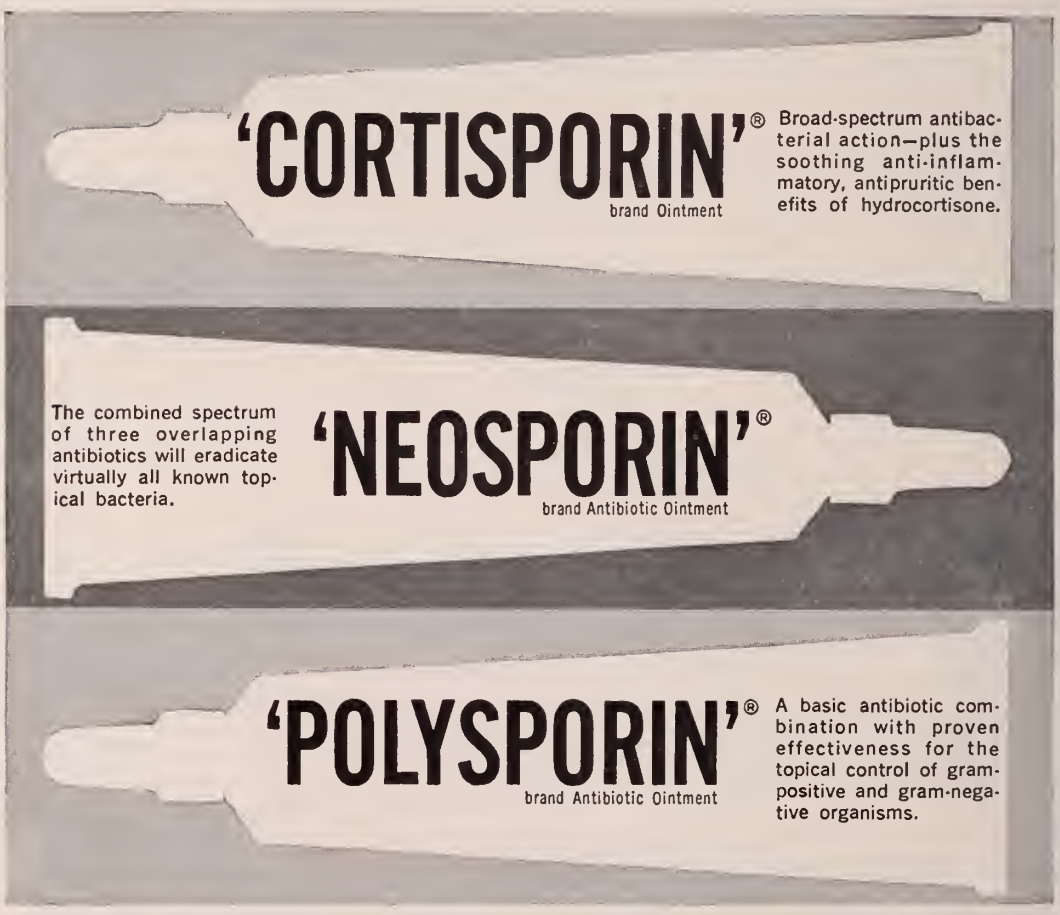

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Society Records

Membership Report as of February 28, 1962

NEW MEMBERS

Richard R. Whereatt, 2020 East Milwaukee Avenue, Janesville.

Stafford W. Gedge, 650 South Central Avenue, Marshfield.

Darrell A. Jaques, 1066 Mather Street, Green Bay.

Richard H. Bibler, N84 W15787 Menomonee Avenue, Menomonee Falls.

Eva Wagner Litton, 418 East Dahl Street, Rhinelander.

William H. Reed, 113 North Third Street, Watertown.

Bernard C. Korbitz, C–230 Cancer Research Hospital, 1300 University Avenue, Madison 6.

Vernon H. Bartley, P.O. Box 457, Eagle River.

Lewis F. Scribner, Jr., 1123 12th Avenue, Monroe.

Hubert W. Simonsen, 2020 East Milwaukee Street, Janesville.

CHANGES OF ADDRESS

Manual Aquino, to 2312 West Capitol Drive, Milwaukee.

Andrew A. Cervenansky, to 3051 South 27th Street, Milwaukee.

Robert J. Nickels, to W171 N8488 Allen, Menomonee Falls.

Charles P. Kauth, to Box 267, Port Washington.

Stephen Dudiak, to 2716 Marshall Court, Madison 5.

J. Francis Wilkinson, to 915 East Summit Avenue, Oconomowoc.

John L. Claude, to 915 East Summit Avenue, Oconomowoc.

J. R. Matt, to 915 East Summit Avenue, Oconomowoc.

Robert A. Holland, to 1344 Creston Park Drive, Janesville.

Laurence Crocker, to 110 East Main Street, Madison.

Richard L. Morgan, to 7927 West Lorraine Place, Milwaukee 10.

Lawrence A. Howards, to 7044 North 28th Court, Milwaukee.

Donald B. Lindorfer, to 5615 West Hampton Avenue, Milwaukee.

Louis L. Bensman, to 4106 North Farwell Avenue, Milwaukee.

W. C. P. Hoffman, to 57 South Main Street, Hartford.

Stanley E. Zawodny, to 7635 West Oklahoma Avenue, Milwaukee.

John C. Ellis, Jr., to 1344 Fish Hatchery Road, Madison 5.

John D. Wilkinson, to 915 East Summit Avenue, Oconomowoc.

Peter B. Theobald, to 915 East Summit Avenue, Oconomowoc.

Bernard J. Schumacher, to 915 East Summit Avenue, Oconomowoc.

D. J. Sievers, to 118 Spring Street, Berlin.

Alwin E. Schultz, to 222 North Midvale Boulevard, Madison 5.

H. G. Decker, to 4567 West Spencer Place, Milwaukee.

Hilbert N. Dricken, to 7635 West Oklahoma Avenue, Milwaukee.

Paul A. Jacobs, 949 North 12th Street, Milwaukee.

Arnold H. Barr, to P.O. Box 227, Port Washington.

Henry C. La Brec, Wood, to 115 North 70th Street, Milwaukee.

Dean D. Miller, Wood, to 2001 South 68th Street, Milwaukee.

Thomas L. Tolan, Milwaukee, to 3030 North Seventh Street, Phoenix, Arizona.

J. M. Sorenson, Rochester, Minnesota, to 1714 East Capitol Drive, Milwaukee 11.

George L. McCormick, Marshfield, to 102 East Main Street, Waukesha.

R. L. MacCornack, Sr., Phoenix, Arizona, to Whitehall.

Viggo B. Olsen, Philadelphia, Pennsylvania to F.P.O. # 78, Chittagong, East Pakistan.

Christo Christoff, Milwaukee, to St. Mary's Hospital, Madison 5.

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Whether it be in electronics or in drugs, modern research requires enormous sums of money spent with considerable boldness; there are more research efforts that fail than succeed. Good public policy is that which most encourages men to search for new things from which all society will profit. Before we wreck the patent system, we might ask whether it is better that somebody have a "monopoly" on tomorrow's miracle drug than that the miracle lie undiscovered.—Editorial, *Wall Street Journal.*

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REFERENCES: 1. Best, E. B., Hightower, N. C., Jr., Williams, B. H., and Carobasi, R. J.: South. M.J. 53:1091, 1960. 2. Analytical Control Laboratories, Organon Inc. 3. Best, E. B., et al.: Symposium at West Orange, N. J., May 11, 1960. 4. Thompson, K. W., and Price, R. T.: Scientific Exhibit Section, A.M.A., Atlantic City, N. J., June 8-12, 1959. 5. Weinstein, J. J.: Discussion in Keifer, E. D., Am. J. Gastro. 35:353, 1961. 6. Ruffin, J. M., McBee, J. W., and Davis, T. D.: Chicago Medicine, Vol. 64, No. 2, June, 1961. 7. Berkowitz, D., and Silk, R.: Scientific Exhibit Section, A.M.A., New York, June 25-30, 1961. 8. Berkowitz, D., and Glassman, S.: N. Y. St. J. Med. 62:58, 1962.

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Obituaries

Dr. Casper C. Skinsnes, physician at the Vernon County Hospital and Home in Viroqua, died in Chicago December 31, 1961, at the age of 75.

A native of Mandal, Norway, Doctor Skinsnes was a 1914 graduate of Loyola University School of Medicine. After internship at Lutheran Deaconess Hospital in Chicago, he received postgraduate training in Philadelphia, Illinois, and Tybingen, Germany. He practiced in China from 1915 to 1942, was in Tanganyika, Africa, for two years, and returned to China from 1946 to 1949. In 1950, he came to Danforth, Illinois, where he practiced for five years before becoming physician at the Vernon County Home and Hospital.

Doctor Skinsnes was a member of the Vernon County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow and three children.

Dr. Neal F. Crowe, Delavan, died January 4, 1962, at the age of 72.

Born in Antigo, Doctor Crowe was a 1913 graduate of Marquette University School of Medicine. Following internship at Milwaukee Children's Hospital, he first practiced at Walworth. Entering military service in World War I, Doctor Crowe was stationed for two years with the medical corps in England. Upon his return he established his practice in Delavan. In 1933 he was co-founder of the Delavan clinic.

Doctor Crowe was a member of the Walworth County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, Ruth; two daughters, and a brother, Dr. J. E. Crowe, of Milwaukee.

Dr. Francis H. Le Wohl, Racine, died January 6, 1962, at the age of 72.

A native of Vienna, Austria, Doctor Le Wohl came to this country in 1909. He was a 1927 graduate of the Marquette University School of Medicine. Following internship at St. Joseph's Hospital in Ashland, he practiced in Peshtigo and Madison before going to Houghton, Michigan, where he practiced for 12 years. He returned to Wisconsin in 1943, practicing at Elkhorn and on the staff at Winnebago State Hospital.

He is survived by his widow, Naomi.

Dr. Jerome W. Fons, Milwaukee, councilor and past president of the State Medical Society of Wisconsin, died January 8, 1962, at the age of 60.

A native of Milwaukee, Doctor Fons was a 1930 graduate of Marquette University School of Medicine. Following his internship at St. Mary's Hospital, Milwaukee, and residency at Johnston Emergency Hospital in the same city, he established his practice in Milwaukee which he maintained for 31 years.

Doctor Fons was a member and past president of The Medical Society of Milwaukee County. He served his State Medical Society as vice-speaker and speaker of the House of Delegates, was president-elect and served as president in 1958. At the time of his death he was a member of the Council. He was also a member of the American Medical Association, past president of the Wisconsin Academy of General Practice, and member of the Wisconsin Society of Obstetrics and Gynecology.

He is survived by his widow, Genevieve, and two children.

Dr. Wilson Cunningham, Platteville, a past president of the State Medical Society of Wisconsin, died January 27, 1962, at the age of 89.

Wilson Cunningham, M. D.

Born in Cobb, Wisconsin, Doctor Cunningham was an 1898 graduate of the Northwestern University Medical School. He interned at Mercy Hospital, Chicago, from 1898 until 1900, coming to Platteville that year to establish the practice which he was to maintain for the next 60 years. Doctor Cunningham established the first hospital in his area of the state soon after his arrival and operated it for 36 years. He was instrumental in the community drive which culminated in the construction of the present Platteville Municipal Hospital.

One of the significant contributions which Doctor Cunningham made to the practice of medicine was his own ingenious carving of bone plates made from young beef cattle for use in repairing fractures. This was in about 1918 before stainless steel came into use.

Doctor Cunningham was a director of the Wisconsin Anti-Tuberculosis Association, the American Cancer Society, and the American Red Cross. He was health officer of the city of Platteville for 30 years.

He was a past president of the Grant County Medical Society, a member of the Council of the State Medical Society of Wisconsin for over 30 years, and served as president of the Society in 1925. He was a member of the American Medical Association, the American College of Surgeons, and one of the three founders of the Tri-State Medical Society.

Surviving are his widow, Ann; and two daughters, Mrs. W. D. Hoard, Fort Atkinson, and Mrs. Mike Groom, McAllen, Texas.

A more detailed account of Doctor Cunningham's medical accomplishments will be published in a forthcoming issue of the *Journal* which will feature items of historical significance.

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Medical Meetings

Postgraduate Courses

Wisconsin Postgraduate Course

The University of Wisconsin Medical Center will present the following postgraduate course at Madison May 17–19:

The Eccrine, Aprocrine and Holocrine Glands of the Skin.

Program chairman is Sture A. M. Johnson, M.D., professor and chairman, department of dermatology, the University of Wisconsin Medical School.

Distinguished experimental and clinical investigators will present the anatomy, physiology and biochemical activity of these glands. The newer concepts of their functions with special reference to hormonal influences will be discussed and the newer concepts of specific disease processes, cystic fibrosis, sweat retention syndrome and others will be presented.

Members of the Academy of General Practice will receive 18 hours of Category 2 credit for the entire two and one-half day course.

Tuition is $50. For further information, write the Coordinator of Postgraduate Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wisconsin.

American College of Cardiology

The 10th Western Cardiac Conference will be held May 28–30 at the Hilton Hotel in Denver. Scientific sessions of the American College of Cardiology will follow the Conference. Registrations will be accepted for both sessions from all physicians. For further information, write the Colorado Heart Association, 1636 Logan Street, Denver 3, Colorado.

National Tuberculosis Association

The National Tuberculosis Association and its medical section, the American Thoracic Society, will hold their annual meeting in Miami Beach, Fla., May 20–23. The National Conference of Tuberculosis Workers will be held simultaneously. Headquarters hotels will be the Deauville and Carillon, with medical sessions held at the Deauville. There is no registration fee.

Upper Peninsula of Michigan Medical Society

The Upper Peninsula of Michigan Medical Society will hold its annual meeting at the Gateway Hotel, Land O'Lakes, Wisconsin, June 15–17. Complete details and reservations may be obtained by writing Paul R. Lieberthal, M.D., 104 S. Suffolk Street, Ironwood, Michigan.

A.M.A. Annual Meeting

Sixty Chicago and Illinois pathologists are now preparing to collect approximately 300 specimens for an exhibit at the American Medical Association's 111th annual meeting in Chicago June 24–28. These specimens of unusual pathology will be brought in each morning of the five-day meeting from hospitals and laboratories in the Chicago area. Specimen collections have now begun and they will be quick frozen to preserve them until the convention opens in McCormick Place. Dr. Samuel A. Levinson, chief pathologist at the L. A. Weiss Memorial Hospital and professor of pathology emeritus at the University of Illinois College of Medicine, is chairman of exhibit planning.

A special weeklong Nutrition and Diet Conference and Exhibit, prepared by the A.M.A. Council on Foods and Nutrition, will put under intense review and discussion infant and child nutrition, lipid metabolim, obesity, nutrition in medical practice, and food, fat and fallout.

Dr. Irving S. Cooper, director of the department of neurologic surgery, St. Barnabas Hospital for Chronic Diseases, New York City, will give physicians a summary of his 10-year investigation, comprising 2,000 consecutive cases, of a bloodless form of brain surgery that relieves once-hopeless cases of tremor and rigidity. Doctor Cooper's technique, recently modified, utilizes freezing to minus 200 degrees centigrade as a surgical tool instead of an ordinary scalpel. Doctor Cooper, who is also connected with New York University Medical Center, will appear on the program, sponsored by the Section on Nervous and Mental Diseases of the A.M.A. Council on Scientific Assembly, Tuesday morning, June 26, at McCormick Place.

Progress of medical science in replacing defective organs and tissues with healthy "spare parts" taken from donors will be reviewed and evaluated in an organ transplantation program, sponsored by the A.M.A. Section on Orthopedic Surgery, Wednesday afternoon, June 27, at McCormick Place. Five physicians who have pioneered in this field of experimental surgery and research in biochemistry and immunology will cover the program. They are: Dr. David M. Hume, of the Medical College of Virginia, Richmond; Dr. Ernst J. Eichwald, Director of the Laboratory for Experimental Medicine, Montana Deaconess Hospital, Great Falls; Dr. Joseph E. Murray, Boston; Dr. Donald A. Roth, Veterans Administration Medical Center, Wood, Wisconsin; and Dr. William F. Enneking, Chief of Orthopedic Surgery at the J. Hillis Miller Health Center, University of Florida at Gainesville.

MEDICAL MEETINGS *continued*

American Medical Women's Association

The American Medical Women's Association extends an invitation to all women physicians attending the A.M.A. Annual Meeting in Chicago to be their guests at a brunch on Sunday, June 24, at 11 a.m. at the Essex Inn. "Medical Woman Power—Can It Be Used More Efficiently" will be discussed by a panel with audience participation. Make reservations before June 22 with the American Medical Women's Association, 1790 Broadway, New York 19, N.Y.

WISCONSIN CALENDAR COMING EVENTS

1962

Apr. 25: Conference on "Care of the Premature Infant," Park Falls Memorial Hospital, Park Falls.

Apr. 26: Conference on "Care of the Premature Infant," Rice Lake High School, Rice Lake.

Apr. 26–28: UW postgraduate course, Psychosomatic Medicine, Dr. David Graham, chrm., Wisconsin Center Building, Madison.

May 3: Half-day course in therapeutics, UW, University Hospital, Madison.

May 8–10: Annual meeting, State Medical Society of Wisconsin, Milwaukee.

May 10–11: UW postgraduate course, Orthopedic Surgery, Dr. H. Wirka, chrm., Wisconsin Center Building, Madison.

May 14: Illinois State Medical meeting at Chicago.

May 17–19: UW postgraduate course, Anatomy, Physiology and Pathology of the Holocrine, Apocrine and Eccrine Glands, Dr. S. Johnson, chrm., Wisconsin Center Building, Madison.

May 18–19: Third regional Rural Health Conference of AMA at Des Moines, Ia.

June 15–17: Upper Peninsula of Michigan Medical Society annual meeting at Land O'Lakes.

June 19–20: Annual meeting of Wisconsin Association of Public Health, Madison.

June 24–28: AMA Annual Meeting, Chicago, Illinois.

July 27–28: SMS Council Meeting, Land o'Lakes.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

University of Illinois Medical Alumni Association

The University of Illinois Medical Alumni Association will hold its annual seminar and reunion banquet during the Illinois State Medical Society meeting May 14. Fifty-year and 25-year reunion classes will be honored at a banquet in the Hotel Sherman. Speaker for the evening will be Dr. Morris Fishbein, professor emeritus and lecturer in medicine at the University of Illinois.

Colorado Postgraduate Course

"Medical and Surgical Aspects of the Retina" will be the subject of the annual postgraduate course in ophthalmology and the summer convention of the Colorado Ophthalmological Society scheduled for July 9–12 at Estes Park, Colorado. The Stanley Hotel will be headquarters for the meeting. Tuition fee for the four-day course is $60 (including a nonrefundable registration fee of $10).

World Forum on Syphilis, Sept. 4–8

World forum on syphilis and other treponematoses, Sheraton Park Hotel, Washington, D.C. Precedes International Congress on Dermatology, Sept. 9–16, at same place. Sponsored by American Venereal Disease Association, American Social Health Association, and United States Public Health Service. Write: Dr. William J. Brown, Venereal Disease Branch, Communicable Disease Center, U.S. Public Health Service, Atlanta 22, Georgia.

American Rhinologic Society, May 16–19

Introductory course on Expanded Surgery of the Nasal Septum and Closely Related Structures, St. Michael Hospital, Milwaukee, Wis. Local committee: Drs. Irwin E. Gaynon, Charles J. Finn, and Frank G. Treskow. Fee of $150 includes meals at hospital. Write: Educational Committee, ARS, 530 Hawthorne Place, Chicago 13, Ill.

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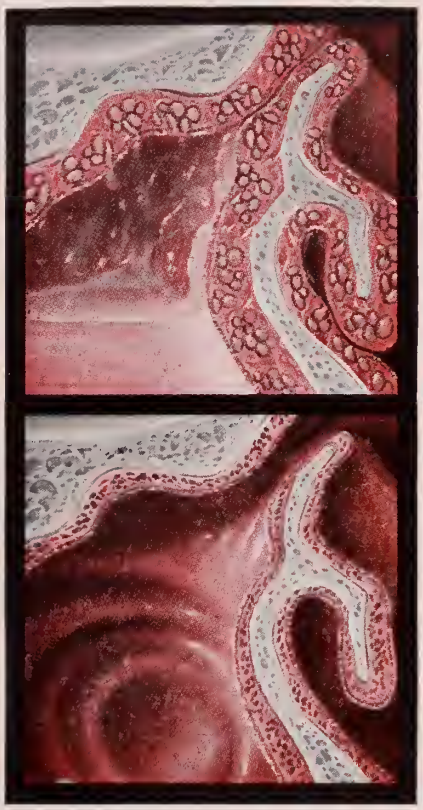

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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. **2.** Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. **3.** Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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MEDICAL MEETINGS *continued*

International Symposium

The third section of an international symposium on "Injury, Inflammation and Immunity" will be held in Elkhart, Indiana, May 15–16. Original papers will be presented and discussed by internationally known medical authorities.

The Elkhart sessions will be chaired by Dr. Lewis Thomas, professor and chairman, department of medicine, New York University, Bellevue Medical Center, New York; Dr. G. Asboe–Hansen, Finsen Institute and the University Hospital, Copenhagen, Denmark; and Dr. Ashley A. Miles, director, The Lister Institute of Preventive Medicine, London, England.

Research departments of Miles Laboratories, Inc. are sponsoring the symposium. Immediately preceding the Elkhart section, other sections of the symposium will be held at Miles' new medical research centers in Stoke Poges, England, and Mexico City. Speakers at those sections also will be present at Elkhart.

The Elkhart section will be held in conjunction with dedication of the pharmaceutical company's new four million dollar research building which will serve as headquarters of the company's international research network.

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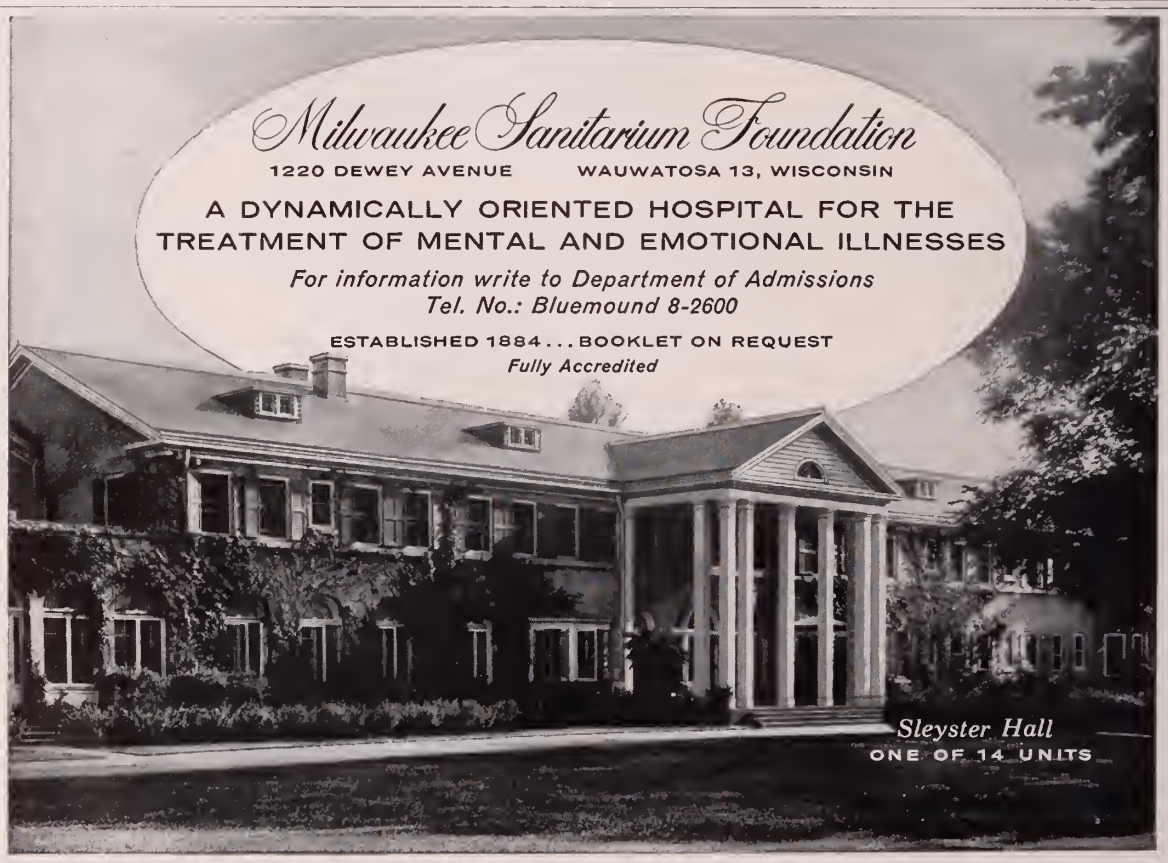

the Wisconsin Medical Journal

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VOL. 61, NO. 5—MAY 1962

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Letters of Interest

NATIONAL PRAISE FOR STATE JOURNALS

To WMJ:

This letter is to formalize our request for permission to reprint the article: "When Malpractice Threatens, Should You Fight or Settle?" which appeared in the January 1962 issue of the *Wisconsin Medical Journal.*

We feel the piece is particularly effective in its writing and its presentation—and reflects the high standards and high quality of the Wisconsin Medical Journal most faithfully. We hope that our presentation can be as effective and can carry the message of the article to all our 165,000 physician-readers throughout the nation.

Our editor, Dan Rennick, has always maintained that some of the best medical journalism in existence is being carried out on the state medical journal level and that one of our own editorial goals should be to bring prime examples of this kind of writing into national prominence wherever possible.

Fred L. Shaw, Jr.
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AN EXPERIENCE WITH HURRICANE CARLA

To WMJ:

I am writing this in reply to your letter, which stated, the paper "Hereditary Hemorrhagic Telangiectasia" would be published. I am certainly sorry I have not replied before this, however my life has been somewhat complicated. The Hurricane Carla was quite an experience, which left a mark which will be difficult to erase. Following this, I was ordered to active duty and then the orders were changed, placing me back in the ready reserves. Dec. 6 I took the first part of the General Surgical Board Exams and on the 13th of this month the second part of the exam was given in New Orleans. I am finally settling back to a normal existence, I hope.

I thought you might be interested in the Hurricane Carla as we saw it. On the Friday evening before the Hurricane struck my wife and I stood on the south shore of the island watching the waves strike the sea wall. We had heard over the radio and TV that Hurricane Carla was bearing down towards the Southern coast of the U.S. The night was peaceful and the sky was full of stars. There was no indication that a monster was lurking out on the sea, except for the rising tide and high waves.

Saturday morning announcements were made that the southern coast of Texas should be vacated. I bundled up the family in the car and took them 150 miles inland. On my return to the island of Galveston, I passed cars, bumper to bumper, extending out 50 miles from Galveston. Indeed the people were taking no chances.

Saturday evening all of the hospital staff was called to duty as the hurricane was expected to strike sometime Sunday. One thousand people came to the hospital for shelter in the next 24 hours.

Sunday the winds and rain blew all day; however, it wasn't until Monday the eye of the hurricane passed just to the west of us.

We lost electricity during a good part of the hurricane and flash lights had to be utilized for surgery and emergency room care. Water was stored in empty blood vacuum bottles and other containers that could be found. There was no water for toilet facilities. Small pails were utilized and these were emptied into larger containers, which were taken to a central collecting area.

Winds were registered up to 120 miles an hour. The waves were so high that they struck the sea wall and splashed over the buildings. The tide rose to the extent that a good piece of the island was under water. The hospital had waist deep water on three sides. Patients were brought in by motor boats.

The rattle snakes left the low portions of the islands and invaded the city. We even found one in the first floor of the hospital.

The basement of the hospital became flooded and ruined all of our supplies as well as ruining the air conditioning unit.

Monday evening we finally went to bed on the hospital floor. As hard as the floor was, no one complained, for everyone was happy to have the worst of it over.

About 2:00 a.m. a noise like a hundred jet planes was heard. The windows, which previously had held well, began to shake as if they would break into a thousand pieces. We were then told a tornado had cut a path through the center of the island and another had hit the west end. It appeared Hurricane Carla was throwing off tornadoes like a Roman candle, as two others missed the island and demolished nearby towns.

Three of us were placed at the entrance of the hospital for triage from 2:00 a.m. to 8:00 a.m. At that time I was sent to one of the large hotels to set up a disaster unit. Transportation was the big problem; consequently physicians were sent in scattered areas to set up disaster units. By this means only high priority patients were transported.

The hotel had patients scattered over four floors. Boards and torn sheets were utilized for splints. A pharmacy next door had been leveled by the hurricane; however, some things were salvaged from the rubble.

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General Surgery, One Week, Sept. 17
Vaginal Surgery, One Week, June 25, August 6
Obstetrics, General & Surgical, Two Weeks, July 16
Pain Relief in Childbirth, 3 Days, July 11
Proctoscopy and Sigmoidoscopy, One Week, July 16
General Practice Review, One Week, October 8
Advanced Electrocardiography, One Week, June 18
Gallbladder Surgery, 3 Days, June 18, October 8
Surgery of Hernia, 3 Days, June 21, October 11
Neuromuscular Diseases, Two Weeks, June 11
Hematology, One Week, June 4
Advances in Medicine, One Week, October 15
Blood Vessel Surgery, One Week, October 22
Fractures and Traumatic Surgery, Two Weeks, June 11, Oct. 1
Diagnostic Radiology, Two Weeks, October 29
Information concerning numerous other continuation courses available upon request.

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LETTERS OF INTEREST *continued*

Wednesday morning the hospital staff was leaving for a much needed rest when a large porch filled with people looking for Red Cross help and shelter collapsed. Another 40 patients were brought to the hospital.

Wednesday afternoon everyone with a shotgun was called to the center of the city to hunt rattle snakes, as they were becoming a terrible menace. For example, one man was struck when he opened a locked car.

Following the hurricane we had an epidemic of diarrhea, which was not serious.

DUANE L. LARSON, M.D.
University of Texas Medical Branch
Galveston, Texas

INVITE ORAL SURGERY MANUSCRIPTS

The American Society of Oral Surgeons wishes to announce the presentation of a cash award at the Forty-Fourth Annual Meeting in New Orleans, October 24–27, 1962. This award will be for superior original manuscripts concerning any phase of research related to oral surgery during the current year. All individuals interested in this competitive award should write: American Society of Oral Surgeons, 840 North Lake Shore Drive, Chicago 11, Illinois.

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County Society Proceedings

DANE

The Dane County Medical Society met April 10 at the State Medical Society building in Madison to make final plans for the Health Fair which the County Society is sponsoring May 23–27 at the Camp Randall Memorial building, Madison. Planned to stimulate interest in medical and allied careers, the publicity committee, under the direction of *Dr. C. W. Stoops*, Madison, has organized a forceful campaign to reach as many citizens of the surrounding area as possible through special newspaper supplements, signs and posters, bumper stickers, and speakers at service clubs as well as over radio and TV.

FOND DU LAC

Members of the Fond du Lac County Medical Society heard *Dr. Ralph Campbell*, Madison professor of obstetrics and gynecology at the University of Wisconsin, talk on "The Treatment of Prolapse of the Uterus" March 22 at the Elks club, Fond du Lac. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from Merck Sharp & Dohme.

LA CROSSE

Dr. Fred J. Ansfield, Madison, addressed the La Crosse County Medical Society March 19 at the Fireside restaurant in La Crosse. Doctor Ansfield, associate professor of cancer research, University of Wisconsin, spoke on "The Role of the Family Physician in Chemotherapy of Disseminated Cancer." His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

MARINETTE–FLORENCE

"Thyroid Disease and Radio-Iodine" was the subject discussed by *Dr. E. C. Albright*, Madison, at the March 14 meeting of the Marinette-Florence and Menominee, Mich., County Medical Societies at Marinette. Doctor Albright is professor of medicine and assistant dean of the University of Wisconsin Medical School.

OUTAGAMIE

The Outagamie County Medical Society and the Outagamie County Pharmaceutical Society held a joint dinner meeting March 15 to discuss poison control centers. Richard S. Strommen, assistant professor with the University of Wisconsin extension services in pharmacy, Madison, was the guest speaker.

PORTAGE

Wisconsin Physicians Service insurance contracts were discussed by Herman L. Toser, insurance director of WPS, at the March 8 meeting of the Portage County Medical Society held at the Hot Fish Shop in Stevens Point. Discussants included *Drs. John A. Litzow, W. A. Gramowski, George H. Anderson* and *Albert M. Kohn*, all of Stevens Point.

Dr. V. A. Benn, Rosholt, discussed problems arising from the care of welfare patients from surrounding counties. It was voted to activate the committee on the welfare fee schedule. The Society voted continued support of a team in the Youth Baseball Association and heard a report of the public relations committee which recommended wider distribution of publications made available by the American Medical Association.

OZAUKEE

The Ozaukee County Medical Society met at the Grafton Hotel in Grafton January 25. Fourteen members heard *Dr. Christopher Graf*, Sheboygan, speak on "Recent Developments in Recurrent Urinary Tract Infections in Children."

VERNON

Officers of the Vernon County Medical Society are:
President—*Dr. R. A. Starr*, Viroqua
Secretary—*Dr. W. N. Otterson*, Westby
Delegate—*Dr. Carl Ender*, Viroqua
Alternate Delegate—*Dr. Lars Gulbrandsen*, Viroqua

WAUKESHA

Dr. Ruth Church, Waukesha, discussed the Waukesha County Health Department at the March 7 meeting of the Waukesha County Medical Society held at the Red Circle Inn at Nashotah. During the business meeting, the secretary was directed to request *Dr. W. D. James*, Oconomowoc district councilor, to make the following recommendation at the next Council meeting of the State Medical Society: that the period of time before football season for W.I.A.A. examinations be extended so that adequate

Physicians whose names appear in italic are members of the State Medical Society.

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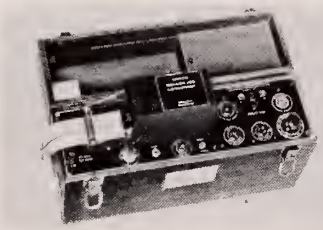

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COUNTY SOCIETY PROCEEDINGS *continued*

examinations may be made in the physician's office rather than inadequate mass examinations at school.

WINNEBAGO

Members of the Winnebago County Medical Society met April 5 at the Menasha Hotel for a dinner meeting at which *Dr. A. V. Pisciotta,* Milwaukee, spoke on "Agranulocytosis and the Relationship of Drugs to Marrow Depression."

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Specialty Society Proceedings

Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine met at the University Club of Milwaukee April 17 to hear Capt. Jack L. Kinsey, MC, USN, director of special projects, Bureau of Naval Weapons, speak on "Polaris and Its Significance to Man."

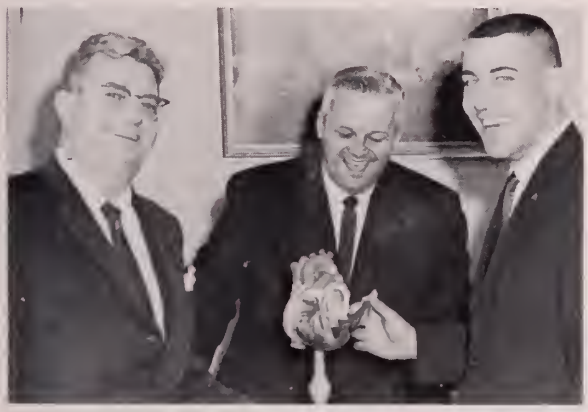
Wisconsin Thoracic Society

The Wisconsin Thoracic Society, medical section of the Wisconsin Anti-Tuberculosis Association, held its 1962 scientific program at Hotel Pfister, Milwaukee, April 14.

American Cancer Society

Iowa County Unit

Dr. Roy G. Glise, Richland Center, medical director of the Fourth Wisconsin District of the Cancer Society, spoke at the kickoff meeting of the Iowa County unit of the American Cancer Society March 22 at the Congregational church in Arena.



Wisconsin Dells Events Photo by Connie Wrzesinski

Examining the heart model presented to the Wisconsin Dells high school by the Wiscansin Heart Association and the Columbia County Heart Cauncil are Dr. C. F. Broderick of the Dells Clinic, Principal Fred Reineking and Ronald Klestinski, high schaal biology instructor.

Wisconsin Heart Association

Columbia County Council

The Wisconsin Heart Association and its affiliate, the Columbia County Heart Council, recently presented a model of the human heart to the science department of the Wisconsin Dells high school. The presentation was made by *Dr. C. F. Broderick* of the Dells Clinic.

The model is hinged so that portions may be opened for more detailed study of the various heart chambers, the valves, and the relationship to the large vessels. It will be a valuable teaching aid in science subjects taught at the high school.

Winnebago County Council

A seminar entitled "Diagnosis and Correction of Surgical Heart Disease" was sponsored by the Wisconsin Heart Association, Winnebago County Council, March 29 at Oshkosh. Dr. C. Walton Lillehei, professor of surgery, University of Minnesota Medical School, spoke on "The Changing Outlook in Heart Diseases" at a dinner meeting which climaxed a professional education program to which physicians from a nine-county area, including Brown, Outagamie, Winnebago, Waushara, Green Lake, Fond du Lac, Sheboygan, Manitowoc and Calumet counties, had received invitations. Speakers at the afternoon session included Dr. Thomas C. Meyer, assistant professor of pediatrics, University of Wisconsin, Madison; *Dr. William J. Gallen*, director, Fairchild Cardiac Study Center, Milwaukee Children's Hospital; and *Dr. John H. Huston*, associate professor of medicine, Marquette University, Milwaukee.

Wisconsin Academy of General Practice

Northeastern Chapter

At the annual meeting of the Northeastern Chapter of the Wisconsin Academy of General Practice held at St. Vincent's Hospital on January 18, the following officers were elected:

President-elect—*Dr. Wallace MacMullen*, Green Bay
President—*Dr. M. A. Warpinski*, Green Bay
Secretary-treasurer—Dr. Gerald Merline, De Pere
Delegates to Wisconsin Academy of General Practice—*Dr. F. E. Zantow*, Oconto; *Dr. S. F. Brusky*, Pulaski; and *Dr. R. M. Waldkirch*, De Pere
Alternate Delegates—*Dr. H. E. Majeski*, Luxemburg; *Dr. J. J. Brooks*, Sturgeon Bay; and *Dr. C. A. Rothe*, Green Bay

Manitowoc Chapter

New officers of the Manitowoc Chapter of the Wisconsin Academy of General Practice are:

President—*Dr. Joseph Steckbauer*, Manitowoc
Vice-president—*Dr. Theodore Teitgen*, Manitowoc
Secretary-treasurer—*Dr. Harry Schaefer*, Manitowoc

Physicians whose names appear in italic are members of the State Medical Society.

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SPECIALTY PROCEEDINGS *continued*

Delegate to Wisconsin Academy of General Practice—Doctor Schaefer.
Alternate Delegate—*Dr. Raymond Yost*, Manitowoc

West Central Chapter

New officers of the West Central Chapter of the Wisconsin Academy of General Practice are:

President—*Dr. Lou Schmidt*, La Crosse
Vice-president—*Dr. G. A. Landmann*, Tomah
Secretary-treasurer—*Dr. Elmer Rohde*, Galesville

Eau Claire–Chippewa Falls Chapter

The Eau Claire-Chippewa Falls Chapter of the Wisconsin Academy of General Practice has elected the following officers:

President—*Dr. P. J. Finucane*, Eau Claire
Vice-president—*Dr. Guy Giffen*, Eau Claire
Secretary-treasurer—*Dr. C. A. Kemper*, Chippewa Falls

Southwest Chapter

Members of the Southwest Chapter of the Academy of General Practice held a series of six refresher courses in Iowa county March 20 to April 24. Instructors from the University of Wisconsin Medical School conducted the course, which covered office medicine, in St. Joseph's Hospital at Dodgeville.

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LOREN J. DRISCOLL, M. D.

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News of Wisconsin Physicians

Dr. Van Driest to South Vietnam

Dr. John J. Van Driest, Sheboygan orthopedic surgeon, left March 29 for South Vietnam where he will serve for six weeks in a Saigon hospital as a volunteer for Orthopedics Overseas, a program sponsored by the American Association of Orthopedic Surgeons. Designed to raise the professional level of physicians in the Republic of Vietnam, the AAOS program is administered through Medico, the organization founded by the late Dr. Tom Dooley and CARE, which have now combined into one organization. Doctor Van Driest's wife accompanied him on the trip which he is taking at his own expense.

A member of the American College of Surgeons since 1955, Doctor Van Driest has been practicing medicine in Sheboygan since 1952. He began his practice in Oostburg in 1947 after completing his education at Lakeland College and the University of Wisconsin School of Medicine. During 1955–56, when he was a captain in the U.S. Army Medical Corps, Doctor Van Driest served in Stuttgart, Germany, as chief of the orthopedic section and assistant chief of surgery at the Fifth American General Hospital.

William Duxbury, M.D.

William Snook, M.D.

Physicians Inspect Fox Lake Center

Dr. William Snook and Dr. William Duxbury were in Fox Lake in March to inspect the new Fox Lake Medical Center in which they are planning to practice after its completion in July. Formal dedication of the Center, which was built by citizens of Fox Lake in cooperation with the Sears-Roebuck Foundation, has been set for July 15.

Doctor Duxbury, whose home is at Tomahawk, Wis., is now practicing at San Bernardino, Calif. Doctor Snook is practicing in Tulare, Calif. Mrs. Snook is a native of Cambria, Wis., and Doctor Snook's parents live in Freeport, Ill. Both physicians are 1960 graduates of George Washington University.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Kurtz Named VA Hospital Director

Dr. Chester M. Kurtz, director of the Veterans Administration hospital at Fort Bayard, N.Mex., since January, 1959, has been named director of the Albuquerque, N.Mex., VA hospital. A native of Milwaukee, Doctor Kurtz received his M.D. degree from Harvard Medical School in 1927. He entered the VA service at Madison in 1956 as assistant director of professional services.

Dr. Weinstein Speaks at Marshfield

Dr. Arvin Weinstein, staff physician in charge of the artificial kidney unit at University Hospitals, Madison, was the principal speaker at a scientific meeting held late in March at the Marshfield Clinic Foundation for Medical Research and Education. Doctor Weinstein discussed the management of kidney failure.

New Chief of Staff at Wood

Dr. Frederick Rachiele, former director of the Veterans Administration hospital at Tucson, Ariz., is the new chief of staff at the Wood Veterans Administration hospital. Doctor Rachiele, a surgeon, is a graduate of the University of Colorado Medical School. He succeeds Dr. Francis G. Dickey who became director of the Dwight (Ill.) Veterans Administration hospital.

Dr. Burris New Sanitarium Director

Dr. B. Cullen Burris, Wauwatosa, has been named medical director of Milwaukee sanitarium. He fills a new post created with the appointment of a dean's committee to advise the mental hospital board.

Dr. Desmond P. McNelis has been appointed clinical director at the sanitarium, the position previously held by Doctor Burris, and *Dr. William L. Lorton* will succeed Doctor McNelis as director of the diagnostic unit. All three are assistant professors of psychiatry at the Marquette University School of Medicine. The advisory committee is headed by *Dr. John S. Hirschboeck,* dean of the school of medicine.

Other members of the dean's committee are *Dr. Eugene S. Turrell,* director of psychiatric services at the hospital, and *Dr. Frederick W. Madison,* clinical professor of medicine.

WISCONSIN PHYSICIANS *continued*

Dr. Harkness Joins Peace Corps

Dr. John W. Harkness, Wauwatosa, is planning to give up his medical practice in January to join a peace corps mission, possibly in Africa.

Janesville AAUW Hears Dr. Puestow

Dr. Karver L. Puestow, professor of medicine at the University of Wisconsin Medical School, spoke to members and guests of the Janesville branch of the American Association of University Women March 27 on his recent trip to the Near East, especially Israel and Jordan.

Dr. Nystrum Heads New Hospital Staff

Dr. Lester E. Nystrum, Medford, has been named president of the medical staff at the new Memorial Hospital of Taylor County which opened its doors to patients March 17. Dr. S. Frank Hesse, Rib Lake, is vice-president and Dr. James R. Keuer, Medford, secretary. The administrative committee also includes *Dr. Walther W. Meyer*, Medford.

On the active status of the medical staff are *Dr. Lester E. Nystrum, Dr. Raymond C. Nystrum*, Doctor Hesse, Doctor Keuer, Doctor Meyer, and *Dr. Elizabeth A. Baldwin*, Marshfield. Doctor Baldwin joined the staff April 23 as anesthesiologist.

All of the physicians with the exception of Doctor Baldwin are occupying the newly constructed Medford clinic building which is located near the site of Memorial Hospital. The old Medford clinic-hospital building has been purchased by Memorial Hospital to serve as a nursing home in the near future. Doctor Baldwin will continue to maintain her residence at Marshfield where her husband, *Dr. Robert S. Baldwin*, is a member of the Marshfield clinic staff and St. Joseph's hospital staff.

Dr. Vognar Opens Office at Mt. Horeb

Dr. Stanley Vognar, formerly of Chicago, has opened an office in Mt. Horeb where he will specialize in gynecology and obstetrics. Born in Laibach, Yugoslavia, Doctor Vognar is a 1948 graduate of the University of Zagreb, Yugoslavia. He was engaged in general practice there for five years and then accepted the residency in obstetrics and gynecology for five years at the University Hospital in Zagreb. Because of encroaching communism, he left his country in 1957 and practiced medicine in Germany for about a year. He came to the United States in 1958 and interned and served his residency in Chicago. He was on the Chicago State hospital staff from 1960 until coming to Mt. Horeb.

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WISCONSIN PHYSICIANS *continued*

Dr. Farbstein at Hazel Green

Dr. Martin E. Farbstein, a native of New York, joined the staff of the Hazel Green Hospital and Clinic March 3. He completed his internship at Cumberland Hospital in New York and during the past six years served at various Army hospitals as a member of the U.S. Army Medical Corps. His wife is a native of Switzerland, and they have three children.

Marshfield News Herald (Dave Lindberg Photo)

Dr. Arvin B. Weinstein, Madison, is shawn with Dr. Dean A. Emanuel, left, and Dr. Ben R. Lawton, right, members of the Marshfield Clinic.

Marshfield Clinic Holds Scientific Meeting

Dr. Arvin B. Weinstein, Madison, physician in charge of the artificial kidney unit at University Hospitals, was principal speaker at a scientific meeting at the Marshfield Clinic Foundation for Medical Research and Education late in March. He discussed the management of kidney failure.

$30,000 Grant to Dr. Gott

A $30,000 scholarship has been awarded to Dr. Vincent L. Gott, assistant professor of surgery at the University of Wisconsin Medical School, by the Markle Foundation of New York City. The five-year grant is one of 25 made this year to young medical scientists in the United States and Canada.

Doctor Gott received his M.D. degree from Yale University in 1953, served his residency at the University of Minneapolis Hospitals, Minneapolis, and came to University Hospitals, Madison, in 1960. During his residency, Doctor Gott was the National Heart Trainee for the U.S. Public Health Service for two years. His work during the period covered by the grant will be in basic investigation and research in heart surgery at the McArdle laboratory in Madison.

Dr. Johnson Directs Clinical Research

Dr. Rhoda E. Johnson has left her private practice in Milwaukee to become assistant director of clinical research on the staff of Lakeside Laboratories, Inc., Milwaukee. Doctor Johnson completed her residency in obstetrics and gynecology in Milwaukee and Evanston, Ill., hospitals and received her M.D. degree from the University of Wisconsin Medical School.

TV Panel Discusses Food

Taking part in the Milwaukee Public Library's weekly television program, "Public Conference," March 25 over station WITI-TV, Milwaukee, were *Dr. Robert Madden*, clinical instructor in medicine, Marquette University; *Dr. Willard Krehl*, director of clinical chemistry at Milwaukee County General Hospital and associate professor of medicine at Marquette University; and Mrs. Dagmar Walch, chief dietitian at the West Allis Memorial Hospital. Their subject was "Are You What You Eat?".

Dr. Murray Talks on Korean War

Dr. Jack Murray, Monroe, talked to Monroe Kiwanians March 22 about the decreased fatality rate of wounded from World War I through the Korean War as from 8.1 per cent to 2.3 per cent. Doctor Murray was a member of the Army Medical Corps during the Korean War.

Cancer Drive Kickoff Hears Dr. Taylor

Dr. Robert D. Taylor, Marshfield, was the featured speaker at the kickoff meeting of the annual American Cancer Society drive in Taylor county March 24 at Medford. Doctor Taylor, who is a graduate of Northwestern Medical School and formerly practiced in a Cleveland clinic, has an associate professorship at Marquette University and is a staff member of Wood county hospital. He is an internist, consultant and diagnostician.

Dr. Grinvalsky Speaks on Cancer

Dr. Henry T. Grinvalsky, Stevens Point, chairman of the Portage county division of the American Cancer Society, discussed cancer and its characteristics at a meeting sponsored by the Woodland Homemakers March 20 at the Methodist Fellowship auditorium in Amherst.

Pippin Clinic Gets New Member

Dr. Robert G. Hansel, a native of Dubuque, Iowa, began his practice with the Pippin Clinic at Richland Center April 1. A graduate of the University of Iowa, Doctor Hansel recently has been associated with the Milwaukee County Hospital.

Dr. Foderick Named Boxing Examiner

Dr. John W. Foderick, Superior, has been appointed examining physician at Superior by the Wisconsin State Boxing Commission.

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WISCONSIN PHYSICIANS *continued*

Dr. Woloschek Addresses Nurses

Dr. Walter Woloschek, Milwaukee, spoke to the Waukesha District Nurses Association on the treatment of the burned patient April 9 at Oconomowoc Memorial Hospital.

Dr. Ferrari to Practice in Green Bay

Dr. Joseph J. Ferrari has opened a practice as a general surgeon at Green Bay. A native of New York, Doctor Ferrari practiced for the past eight years at Rockville Centre, L.I. He is a graduate of Fordham University and the New York Medical College and took his residency at the Meadowbrook County Hospital in New York. He served with the U.S. Army during World War II.

J. J. Ferrari, M. D.

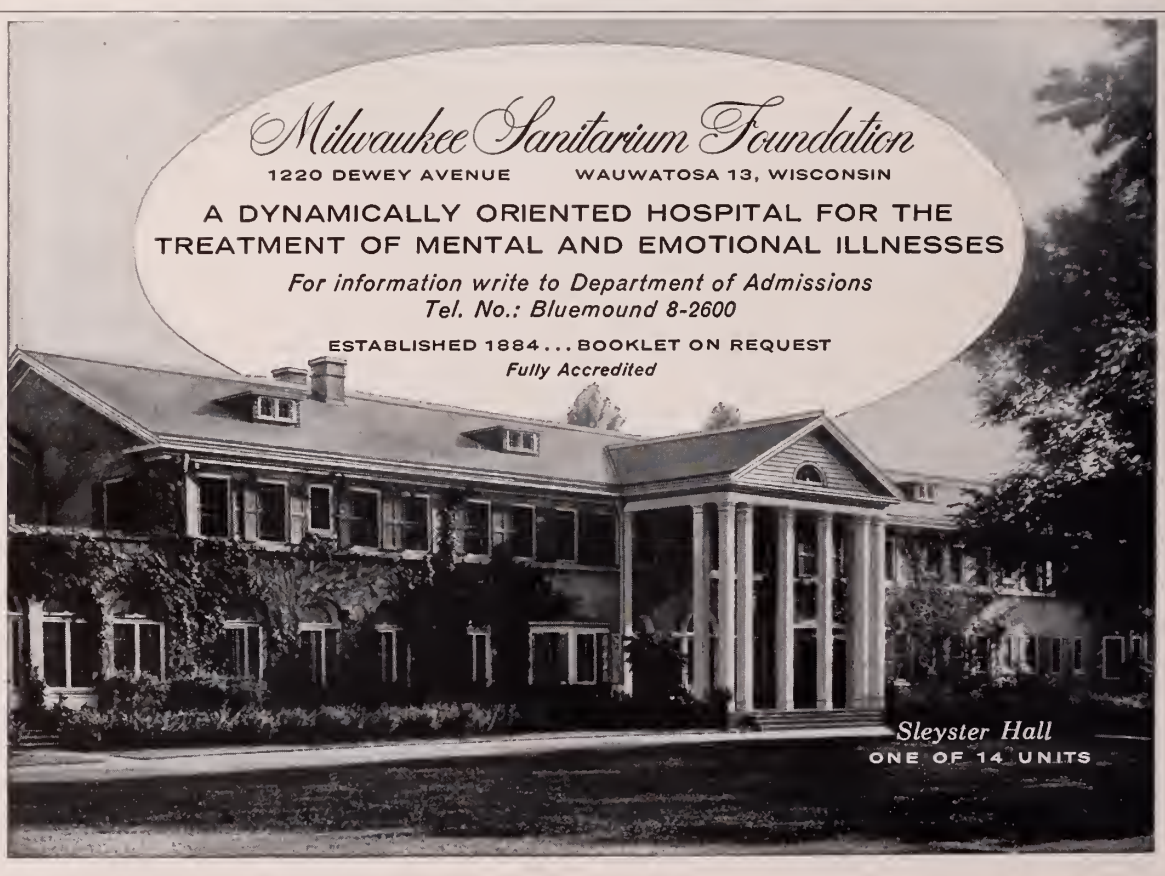
Dr. Hartman Honored by Alma Mater

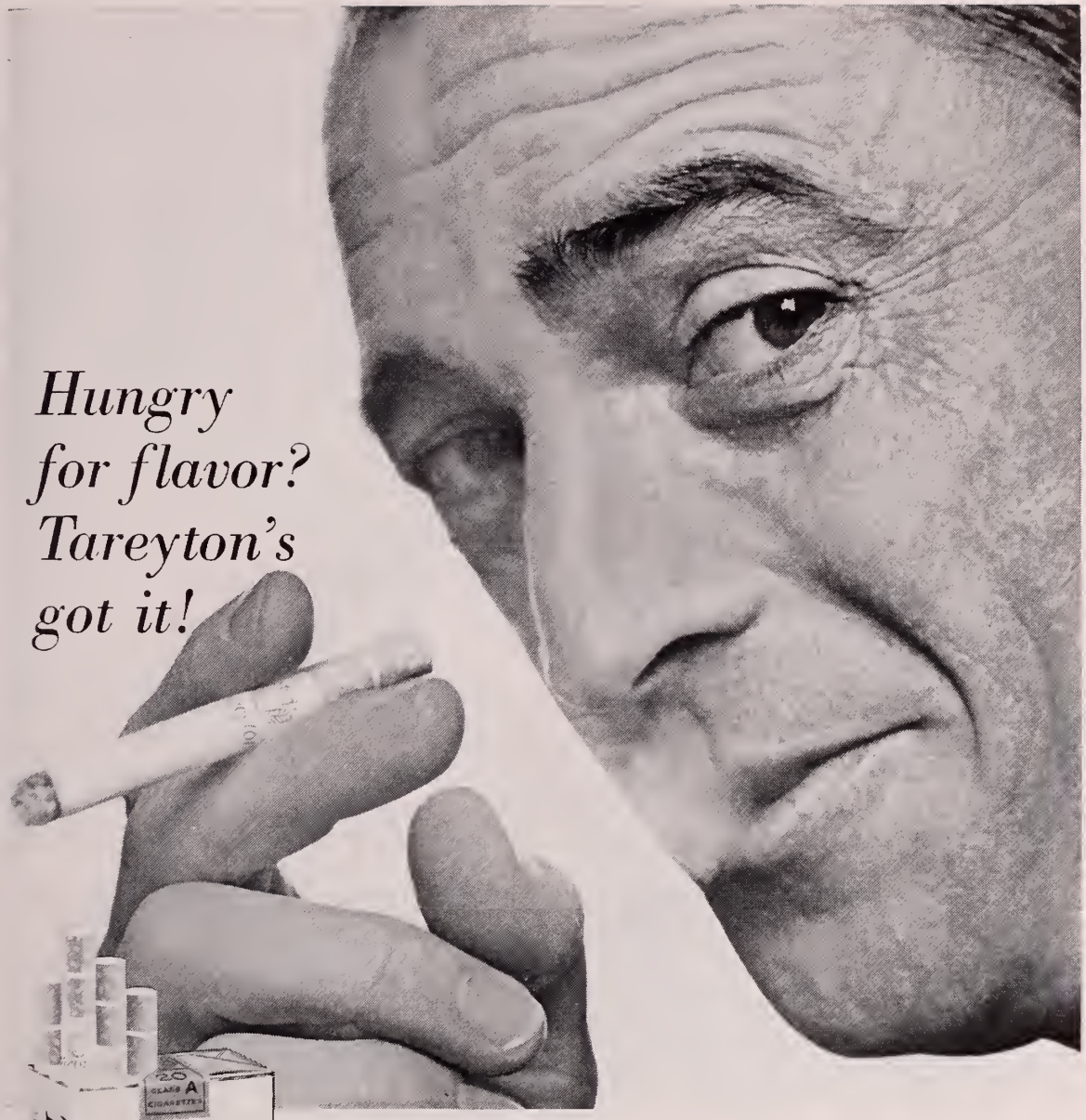
Dr. Irving H. Hartman, 92, who has lived in Madison for the past three years, was presented a distinguished service award recently from the University of Pennsylvania School of Medicine in recognition of his distinguished service to the school. Doctor Hartman is the father of Mrs. Ralph E. Axley, Madison. A senior alumnus of the University of Pennsylvania, Doctor Hartman was graduated from the college in 1895. He practiced medicine for a time at Cleveland, Ohio, and later practiced at Reading, Pa. He was chief of medical services at the Reading hospital from 1917 to 1934, when he retired. He then practiced medicine on a limited basis until he was 87.

Dr. O'Brien Moves to La Crosse

Dr. Marilyn J. O'Brien, who has been senior pathologist at Cook County Hospital of Chicago for the past year, has joined the Department of Pathology of La Crosse Lutheran Hospital and Gundersen Clinic. Doctor O'Brien, a native of Chicago, received her B.S. degree from Loyola University in 1947 and her M.D. degree from the University of Illinois Medical School of Chicago in 1955. She served her internship at St. Francis Hospital, Evanston, Ill., and received her residency training in pathology at Research and Educational Hospitals of Chicago from 1956 to 1961.

Doctor O'Brien is a member of the Chicago Medical Society of Illinois, the American Medical Association and the College of American Pathologists. She also has her American Board Certification of Anatomical Pathology.





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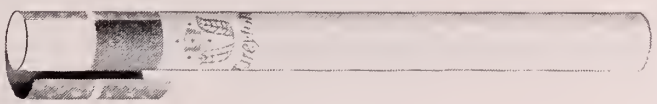

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WISCONSIN PHYSICIANS *continued*

Dr. Conley Talks on Cancer

Dr. James Conley, associate clinical professor of surgery at Marquette University, spoke on "Progress in Cancer Treatment" before the Saint Monica society of St. Monica church, Whitefish Bay, March 25. Doctor Conley is vice-president and a member of the board of directors of the American Cancer Society.

Reception Honors Dr. Love

About 100 residents of Cuba City attended a reception March 25 for Dr. Robert Love, formerly of Stratton, Nebraska, who has recently joined the staff of the Cuba City Medical Center. The reception was held at the home of Mr. and Mrs. Kenneth Creswick in Cuba City.

4–H Club Hears Dr. Karsten

Dr. Fred Karsten, Horicon, spoke on health at a meeting of the Rock River Royals 4-H Club March 12 at Horicon.

Dr. Olson Attends Minnesota Course

Dr. Lester J. Olson, Spooner, attended a three-day course on fractures and related trauma which was given by the orthopedic department of the University of Minnesota and the Mayo Clinic at the University of Minnesota in March.

Dr. Kalb Presents Paper

Dr. Clifford H. Kalb, Milwaukee, presented a paper on "Clinical Experiences with Emulsified Extracts" at the 18th Congress of the American College of Allergists held in Minneapolis, Minn., early in April. Doctor Kalb also served as chairman of the panel presentation on bronchopulmonary physiologic therapy.

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Hubert H. Blanchard, M. D. — Richard O. Barnes, M. D.
John E. Leach, M. D. — Preston W. Thomas, M. D.

Obituaries

Dr. George M. Hoffman, a Manitowoc physician for 31 years, died January 28, 1962, at the age of 58.

A native of Manitowoc, Doctor Hoffman was a 1930 graduate of Marquette University School of Medicine. Following internship at St. Elizabeth Hospital, Appleton, he established his practice in Manitowoc.

A past president of the Manitowoc County Medical Society, Doctor Hoffman was a member of the State Medical Society of Wisconsin and American Medical Association. He was also a registered pharmacist and served as a member of the State Board of Pharmacy. In his own community, he served as city health commissioner from 1933 to 1939 and was assistant Manitowoc County coroner.

Surviving are his widow, Ruth, and one child.

Dr. Herman F. Derge, a practicing physician in Eau Claire for 53 years, died January 29, 1962, at the age of 78.

Born in Eau Claire, Doctor Derge was a 1908 graduate of Johns Hopkins Medical School, Baltimore, Maryland, and interned at Johns Hopkins Hospital from 1908 to 1909. He returned to Eau Claire that year to establish his practice. Doctor Derge served in the Army Medical Corps during World War I. In 1921, he helped found the Eau Claire Clinic.

He was an honorary member and past president of the Eau Claire-Dunn-Pepin County Medical Society, a life member of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Surviving are his widow, Margaret; and two daughters, Mrs. Ned G. Fleming, Marshfield, and Mrs. Leonard J. Seyberth, Eau Claire.

Dr. Alfred D. Beutler, Milwaukee, a specialist in internal medicine, died February 13, 1962, at the age of 70.

Born in Reichenbach, Germany, Doctor Beutler was a 1920 graduate of the University of Breslau and Berlin Medical School. He completed residencies at both Breslau and Berlin. In 1927, he established his practice in Berlin where he continued until 1935. The following year he came to the United States. He established his practice in Milwaukee where he practiced until the time of his death.

Doctor Beutler was a member of The Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Kathe Beutler, M.D.; one daughter, Ruth Nishimura, Ph.D., Princeton, N.J.; and two sons, Ernest Beutler, M.D., Arcadia, Calif., and Frederick J. Beutler, Ph.D., Ann Arbor, Mich.

Dr. Robert L. Cowles, a general practitioner in Green Bay for 40 years, died February 22, 1962, at the age of 71.

A native of Green Bay, Doctor Cowles was a 1913 graduate of Northwestern University Medical School. Following internship at Cook County Hospital in Chicago, Ill., from 1913 to 1915, he established his practice in Green Bay. He retired in 1955.

A past president of the Brown County Medical Society, he was a member of the State Medical Society of Wisconsin, American Medical Association, and the Wisconsin Society of Obstetrics and Gynecology.

Surviving are his widow, Emily, and three children.

Dr. Alfred C. Radloff, Plymouth, a physician in central Wisconsin for more than 50 years, died February 22, 1962, at the age of 81.

A native of Germany, Doctor Radloff was a 1904 graduate of Milwaukee Medical College. He interned at Trinity Hospital, Milwaukee, and practiced in Eden, Wisconsin, for six years before taking postgraduate studies in Berlin, Vienna, Milan and Paris. He practiced in Paris for a time, returning to this country in 1913 to establish his practice in Plymouth.

Doctor Radloff was a past president of the Sheboygan County Medical Society and an alternate to the State Medical Society House of Delegates from his county. He was a life member of the State Medical Society and a member of its Fifty Year Club. He was also a member of the American Medical Association, and an honorary member of the Milwaukee Academy of Medicine.

Surviving are his widow, Florence; two daughters, Mrs. Marian Sterling, Columbia, Mo., and Mrs. Helen Hough, Beverly Hills, Calif.; and a son, William, Whitefish Bay.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

Facts about

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UPGRADING

Wisconsin Physicians Service has been attempting more aggressively to improve surgical-medical benefits to subscribers who are covered under its "B" contract.

Subscribers who hold the "B" schedule benefit contract are now being encouraged to submit the additional premium which will provide an upgrading to the "A" schedule.

Forty-three per cent of 775 out of 1,752 persons who received the initial "upgrading" offer decided to accept it. This result is in the period Feb. 26, 1962, to April 9, 1962.

In the non-group category, 356 Plan "B" contract holders permitted WPS to change their coverage to Plan "A". Of these, 174 were single contracts and 182 were family contracts.

In the conversion category, 399 subscribers authorized the upgrading of coverage. Of that number 234 represented single contracts and 165 were family contracts.

WPS, in addition, is encouraging upgrading from "A" schedule benefits to the Special Service Contract. The WPS Major Illness contract will shortly be made available to holders of the Century Plan and the other WPS surgical-medical programs.

In the final analysis, it is far better for an individual to have some type of health insurance benefits contract in effect, however inadequate, than to have none. Where the income limitations of the individual and family do provide full payment to WPS participating physicians—representing an increasingly smaller percentage of the total working population—the plan "B" contract serves a valuable purpose in cementing good physician-patient relationships.

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Society Records

Membership Report as of March 31, 1962

NEW MEMBERS

Robert R. Baumann, The Monroe Clinic, Monroe.
Francis Kruse, Jr., Marshfield Clinic, Marshfield.
Richard D. Sautter, 630 South Central Avenue, Marshfield.
Stephen C. Copps, 1836 South Avenue, La Crosse.
Theodore Rowan, 113 West Maple Avenue, Beaver Dam.
Keith E. Buchanan, 1029 Depot #1, Little Chute.
Stanley L. Betts, 716 East Second Street, Merrill.
Charles A. Desch, 217 Wisconsin Building, Waukesha.
Stephen Sipos, 6820–14th Avenue, Kenosha.
A. Walid Burhani, 1202—60th Street, Kenosha.
Dorothy R. Conzelman, 1202–60th Street, Kenosha.
Clifton E. Peterson, 6401 Sheridan Road, Kenosha.
Hugh P. Rafferty, 6530 Sheridan Road, Kenosha.
Ann G. Schierl, Stevens Point.
Harold L. Conley, Dells Clinic, Wisconsin Dells.
John E. McKenna, 1125 Superior Street, Antigo.

CHANGE OF ADDRESS

B. J. Klamecki, to 625 North Milwaukee Street, Milwaukee 2.
Paul R. Glunz, to 1706 South Palmetto Avenue, Marshfield.
Gerald P. Gredler, to 305 East Court Street, Janesville.
J. P. Hartwick, to 1710 South East Lane, New Berlin.
Donald J. Heyrman, to W140 N7691 Lilly Road, Menomonee Falls.
W. G. Smirl, to 723 Clinton Street, Waukesha.
George R. Andrews, to 605½ Third Street, Wausau.
W. F. Smejkal, to 601 Reed Avenue, Manitowoc.
C. T. Droege, to 810 North 20th Street, Superior.
K. L. Zucker, to 1825 South Webster, Green Bay.
J. J. Ferrari, to 305 East Walnut Street, Green Bay.
J. A. Ottum, to 535 South Monroe, Green Bay.
C. E. Quandt, to 226 North Sanborn Avenue, Jefferson.
L. O. Langer, Jr., to 2708 Matilda Street, St. Paul 17, Minnesota.
James B. Shack, Highland, to 924 East 4-Mile Road, Racine.
E. M. Schmidt, Redgranite, to 122 North Pearl Street, Berlin.
Guy W. Holmes, Wood, to 328 State Street, Marinette.
Mac C. Roller, Chetek, to 619 Walnut, Whiteland, Indiana.
Franklin N. Roemhild, Prairie Farm, to 114 Fourth Street, Watertown.
T. W. Klein, Florida, to Route 1, Milton Junction.
T. J. Martens, Athens, to 1172 Fifth Street, Monterey, California.
E. F. Daley, Gillett, to Manawa.
E. W. Kreutzer, Middleton, to 4522 Greenmeadow Road, Long Beach 8, California.
L. E. Creasy, Florida, to South Wayne.
Stanley L. Grosshandler, Milwaukee, to 5861 Fulham Court, Greendale.
J. L. Nolan, Menomonie, to 237 Wisconsin Avenue, Waukesha.
T. L. Tolan, Arizona, to 1631 East Hampton Road, Milwaukee 17.
Mel Feinberg, Milwaukee, to 6201 North California, Chicago, Illinois.

PULMONARY PHYSIOLOGY LABORATORY ESTABLISHED IN MILWAUKEE

A Pulmonary Physiology Laboratory has been established at Milwaukee Children's Hospital through a grant of the National Cystic Fibrosis Foundation to the Department of Pediatrics of Marquette University School of Medicine. Patients suspected of, or suffering from cystic fibrosis will be seen at the hospital as out-patients following the referral by their private physician. Full diagnostic facilities are available; however, the main study and evaluation will be directed towards the pulmonary involvement of patients with cystic fibrosis. There will be no charge for these services for patients with cystic fibrosis. Appointments for patients can be obtained by a referring physician through the out-patient department of Milwaukee Children's Hospital (DIvision 4–7100, Mrs. Lacey), or by CF patients after a letter of referral has been obtained from their physician.

The laboratory will be one of 24 Cystic Fibrosis Centers now operating in the U.S., which were set up with the aim to increase our knowledge of this disease, to assist the practicing physician in treating and evaluating the patient with cystic fibrosis and to perform studies regarding the pathogenesis, course and therapy of the disease.

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Medical Meetings
Postgraduate Courses

American College of Physicians

The American College of Physicians will present a postgraduate course on "Psychiatry for the Internist" June 4–8 at the Psychiatric Institute, University of Maryland Hospital, Baltimore, Md. Course limited to 40. Fee for A.C.P. members, $60; nonmembers, $80. Further information may be obtained from Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia 4, Pa.

American College of Chest Physicians

The American College of Chest Physicians will hold its five-day annual meeting at the Morrison Hotel, Chicago, June 21–25. The scientific program will include postgraduate seminars, open forums, a cine symposium, round table luncheon sessions, and motion pictures and will cover such topics as tuberculosis, underwater physiology, chest roentgenology, cardiopulmonary trauma, histoplasmosis, congenital heart disease and cardiac surgery.

On Monday, June 25, there will be a joint meeting between the American College of Chest Physicians and the American Medical Association at McCormick Place, Chicago's new convention center.

For additional information, write Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Colorado Postgraduate Course

The University of Colorado School of Medicine will offer a postgraduate conference on "Management and Rehabilitation of Patients with Arthritis" July 5–7 at Denver, Colorado.

Especially designed for nurses, social workers, physiotherapists, occupational therapists, hospital administrators and public health personnel, the conference will offer a basic review and background information as well as a survey of new developments in many phases of the problems related to the care of the patient with arthritis. Concepts of disease mechanisms, diagnosis, management, and rehabilitation will be among the subjects discussed.

For further information, contact C. Wesley Eisele, M.D., Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver 20, Colo.

Rocky Mountain Cancer Conference

The 16th Annual Rocky Mountain Cancer Conference will be held at the Brown Palace West Hotel, Denver, July 13–14, and will feature panel discussions on "Neoplasms Complicating Pregnancy" and "Carcinoma of the Colon." Application has been made for AAGP accreditation for the conference.

Speakers on the scientific program will include Christopher J. Duncan, M.D., Brookline, Mass.; William H. Gordon, M.D., Lubbock, Tex.; George E. Moore, M.D., Buffalo, N.Y., and James W. Reagan, M.D., Cleveland, Ohio.

The Rocky Mountain Cancer Conference, held annually in Denver, is co-sponsored by the Colorado Division of the American Cancer Society and the Colorado Medical Society. Further information may be obtained by writing Rocky Mountain Cancer Conference, 1809 East 18th Ave., Denver 18, Colo.

American Society of Anesthesiologists

July 18–20 the Second Annual Postgraduate Course in Anesthesiology will be sponsored by the American Society of Anesthesiologists in Seattle, Wash.

September 3–7 the First European Congress in Anesthesiology will be held in Vienna.

The Society's special charter flight to Europe for the Vienna congress has been sold out. Arrangements are being made for a special round trip rate for groups of 25 persons. Interested members may contact E. M. Papper, M.D., Director, Anesthesiology Service, The Presbyterian Hospital in the City of New York, Columbia Presbyterian Medical Center, 622 West 168th Street, New York 32, N.Y., or Ralph S. Sappenfield, M.D., 4444 Island Road, Miami 37, Florida.

October 20–26 the American Society of Anesthesiologists will hold its annual meeting at the Statler Hilton Hotel in New York City.

December 5–8 the sixteenth Postgraduate Assembly in Anesthesiology of the New York State Society of Anesthesiology Inc., will be held at the Hotel New Yorker, New York City.

March 25–29, 1963, the Biennial Western Conference on Anesthesiology will take place at Hawaiian Village, Honolulu.

Interstate Postgraduate Medical Assembly

A scientific meeting of the Interstate Postgraduate Medical Assembly is scheduled for October 1–4 at the Palmer House, Chicago.

The Medical Society of Milwaukee County

The Medical Society of Milwaukee County has scheduled its second annual scientific meeting for November 14–15 in Milwaukee.

Wisconsin Society of Pathologists

The Wisconsin Society of Pathologists will hold its summer meeting at Eagle Waters Resort in

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1. King, J. C.: Int. Rec. Med. 172:669, 1959. 2. Weiner, L. J., and Bockman, A. A.: Sci. Exhibit, A.M.A., Ann. Meet., New York City, June 26-30, 1961.

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See "IN BRIEF" on the next page

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PRACTICAL PEDIATRIC DERMATOLOGY

By Morris Leider, M.D., Associate Professor of Dermatology and Syphilology, New York University Post-Graduate Medical School, New York, N. Y.; Visiting Physician in Charge, Service of Dermatology, Bellevue Hospital, New York, N. Y.; Associate Attending Physician, University Hospital and New York University–Bellevue Medical Center, New York, N. Y.; Diplomate of the American Board of Dermatology and Syphilology. C. V. Mosby Co., St. Louis, Mo., 1961. 437 pages. Price: $13.75.

HOSPITALS, DOCTORS AND DOLLARS

Reports and opinions on our Good Samaritans, who are having some bad times. By Robert M. Cummingham, Jr. F. D. Dodge Corp., New York, 1961. 275 pages. Price: $6.95.

MEMOIRS OF A MEDICO

By Dr. E. Martinez Alonso. Doubleday & Co., Inc. Garden City, New York, 1961. 335 pages. Price: $4.50.

SOMATIC STABILITY IN THE NEWLY BORN

By G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P.; and Maeve O'Connor, Little, Brown & Co., Boston, Mass., 1961. Sponsored by Ciba. 393 pages. Price: $10.00.

THE MEDICINE SHOW

Some Plain Truths about Popular Remedies for Common Ailments. By the editors of Consumer Reports. Simon and Schuster, New York, 1961. 251 pages.

PREVENTIVE MEDICINE IN WORLD WAR II

Volume V—Communicable Diseases. Published under the direction of General Leonard D. Heaton, The Surgeon General, United States Army. Office of the Surgeon General, Dept. of the Army, 1960. 530 pages.

APPRAISAL OF CURRENT CONCEPTS OF ANESTHESIOLOGY

By John Adriani, M.D., Professor of Surgery, Tulane University School of Medicine, New Orleans, La.; Clinical Professor of Surgery & Pharmacology, Louisiana State University School of Medicine, New Orleans, La.; Director, Dept. of Anesthesiology, Charity Hospital of Louisiana, New Orleans, La. C .V. Mosby Co., St. Louis, Mo., 1961. 279 pages. Price: $7.75.

REHABILITATION OF A CHILD'S EYES

By Herbert M. Katzin, M.D., F.A.C.S., Director & Board Member, Eye Bank Laboratory, and Attending Surgeon, Manhattan Eye, Ear and Throat Hospital, New York, N. Y. C. V. Mosby Co., St. Louis, Mo., 1961. 107 pages. Price: $3.75.

RELIEF OF SYMPTOMS

By Walter Modell, M.D., F.A.C.P., Director of Clinical Pharmacology and Associate Professor of Pharmacology, Cornell University Medical College, New York, N. Y.; Attending Physician, New York Veterans Administration Hospital, New York, N. Y.; Associate Visiting Physician, Bellevue Hospital, New York, N. Y.; Member, General Committee on Revision, United States Pharmacopeia XVII; Editor, Clinical Pharmacology and Therapeutics. C. V. Mosby Co., St. Louis, Mo., 1961. 374 pages. Price: $11.50.

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County Society Proceedings

BROWN

Mr. Robert B. L. Murphy, Madison, counsel for the State Medical Society, discussed the law of subpoena passed by the Wisconsin Legislature in 1961 at the May 3 meeting of the Brown County Medical Society held in the Green Bay Elks Club.

JEFFERSON

Members of the Jefferson County Medical Society heard *Dr. Francis J. Millen*, Milwaukee, talk on "Headaches—Their Differential Diagnosis and Treatment" April 19 at the Meadow Springs Country Club in Jefferson. Doctor Millen is associate clinical professor of neurology at Marquette University. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from Merck Sharp and Dohme.

OUTAGAMIE

"Show me the pipe, cigarette and cigar smokers in this room and I'll show you the oral cancer victims of tomorrow," *Dr. Robert J. Samp*, Madison, told a joint meeting of the Outagamie County Medical Society and the Outagamie County Dental Society April 19. "The real cure is to eliminate the cause, which is man's personal habit," he told the group. Doctor Samp's talk on "Oral Surgery" was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

OZAUKEE

Members of the Ozaukee County Medical Society held two meetings recently at the Grafton Hotel, Grafton. Speakers were *Dr. Otto Stewart*, orthopedic surgeon, and *Dr. Christopher Graf*, urologist, both of Sheboygan.

PIERCE-ST. CROIX

The Pierce-St. Croix County Medical Society held a joint meeting with the pharmacists on April 17.

WAUKESHA

Members of the Waukesha County Medical Society met in Delafield April 4.

Physicians whose names appear in italic are members of the State Medical Society.

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News of Wisconsin Physicians

Dr. Hans Reese to Retire in June

Dr. Hans Reese, Madison, internationally distinguished authority on unusual disorders of the nervous system, will retire from his active professorship in psychiatry and neurology at the University of Wisconsin Medical School in June. He was a founder of the U. W. Psychiatry and Neurology Departments when they started 37 years ago as a single department.

Born in Bordesholm in Holstein, Germany, in 1892, Doctor Reese received his M.D. degree from the University of Kiel in 1917 and did postgraduate work at the University of Hamburg. He came to this country in 1920 to study multiple sclerosis, and returned again in 1924 to be a guest research assistant at the Wisconsin Psychiatric Institute and to stay on as a staff member. In 1925 he was asked to help form the new Neuropsychiatry Department in the four-year program offered for the first time in the University of Wisconsin Medical School. He became a full professor in 1929 and was chairman of the Neuropsychiatry Department in 1940, 1946 and 1954–56.

Hans Reese, M.D.

During World War II Doctor Reese joined the Office of Scientific Research Development in Washington as a consultant. He was a combat scientist in 1944–45 and medical adviser to the U.S. Bombing Survey (Air Corps).

In 1959 Doctor Reese taught at several Japanese universities under U. S. Public Health Service sponsorship. He was made an honorary member of the Japanese Society of Neurology and he hopes to return to Japan to teach after retirement.

In 1961 he spent six months at the University of Alexandria, Egypt, on a Fulbright visiting professorship.

Doctor Reese has been president and a director of the Muscular Dystrophy Association of America, president of the American Neurological Association, and president of the American Board of Psychiatry and Neurology.

Doctors Attend Nevada Meeting

Several Wisconsin physicians attended the four-day scientific meeting of the American Academy of General Practice held in Las Vegas, Nev., in April. Among them were *Dr. Leo W. Peterson*, Sun Prairie; *Dr. L. L. Olson*, Darlington; *Dr. Grant Stone*, Berlin; *Dr. Lloyd J. Steffen*, Plymouth; *Dr. H. J. Kief*, Fond du Lac, and *Dr. A. B. Kores*, Beaver Dam.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Salibi Becomes U.S. Citizen

Word has come from Dr. Bahij S. Salibi, neurological surgeon with the Marshfield Clinic, that he "would like to announce with pleasure and pride that I am now a full citizen of the United States of America." Doctor Salibi's Certificate of Naturalization was issued in Wood County Dec. 5, 1961.

Dr. Winkler Donates Birds to College

A large collection of mounted birds recently was donated to Central State College, Stevens Point, by *Dr. H. A. Winkler*, Pardeeville, recognized bird authority. The birds are being used by the biology department.

Iola Gets Emergency Doctor

Dr. Robert Buxbaum, a resident physician at University Hospitals, Madison, has been engaged by the Iola Hospital Board to serve the Iola area temporarily following the sudden loss of Iola's two physicians, *Dr. Else Knudsen* and *Dr. Ralph Wiley*.

Waukesha Nurses Hear Dr. Woloschek

Dr. Walter J. Woloschek of the Burn Center at St. Mary's Hospital, Milwaukee, was guest speaker at the April 9 meeting of the Waukesha District Nurses Association held at the Oconomowoc Memorial Hospital. He explained that the Burn Center has a team of specially trained nurses who care for the patients 24 hours a day. Treatment is prescribed every hour for most patients, and every half-hour for severely burned cases.

J.A.M.A. Publishes Bardenwerper Article

Dr. H. William Bardenwerper, assistant medical director of the Northwestern Mutual Life Insurance Company, Milwaukee, is the author of "Serum Neuritis from Tetanus Antitoxin" which was published in the March 10, 1962, issue of the Journal of the American Medical Association. In his article, Doctor Bardenwerper emphasized the need for increased public recognition of the importance of vaccination with tetanous toxoid and the need for booster shots every four or five years.

Cancer Films Given Public Showing

Films on cancer, "A Doctor Speaks His Mind" and "From One Cell," were given a public showing at the Markesan Library Clubroom and the Kingston school during the afternoon and evening of

gratifying relief for

WISCONSIN PHYSICIANS *continued*

April 24. *Dr. Paul Plueddeman,* Markesan, was the guest speaker for the afternoon meeting.

Dr. Nowack Resigns Health Office

Dr. L. W. Nowack, Watertown, has resigned as city health officer because of health reasons. High tribute was paid Doctor Nowack by Mayor Robert P. White, who accepted the resignation regretfully.

Dr. Kundert Directs Guidance Clinic

Dr. Elizabeth Kundert has been appointed temporary director of the Barron-Polk guidance clinic which opened in Turtle Lake April 24. Doctor Kundert, who has agreed to serve in this capacity until a permanent director can be engaged, received her medical education from the University of Wisconsin and the Women's Medical College of Pennsylvania at Philadelphia. She is certified as a specialist in psychiatry by the American Board of Psychiatry and Neurology, is a fellow of the American Psychiatric Association and a member of the American Orthopsychiatric Association. She has been practicing part time in the Eau Claire area since she retired in 1955 as director of the Vermont State Guidance Clinics, a post she held for many years.

Medical Assistants Hear Dr. Feulner

Dr. R. C. Feulner, radiologist at the Waukesha Memorial Hospital, explained the procedures used in his department to members of the Waukesha County Medical Assistants Society at an April meeting.

Arcadia Gets New Doctor

Dr. Don H. Martin, recently on the staff of the U. S. Naval Hospital in San Diego, Calif., joined the Arcadia Medical Clinic early in May immediately following his discharge from the U. S. Navy. Born in Norton, Kan., Doctor Martin completed the latter part of his secondary education at Chilton High School. His premedical studies were taken at the University of Wisconsin and he received his M.D. degree from Marquette University School of Medicine. He completed his internship at Mercy Hospital, Des Moines, Ia., and later spent a short time on the staff of Milwaukee County Hospital for mental diseases. He entered the Navy in 1960.

Dr. Maresh Talks on Alaska

Dr. Frank Maresh, Milwaukee, who served as director of the hospital at Barrow, Alaska, showed scientific and human interest glimpses of life in the far northwest corner of the United States in an illustrated talk to members of the creative writing class at the University of Wisconsin, Kenosha Extension Center, April 4. Doctor Maresh traveled extensively in Alaska during the five years he was stationed there.

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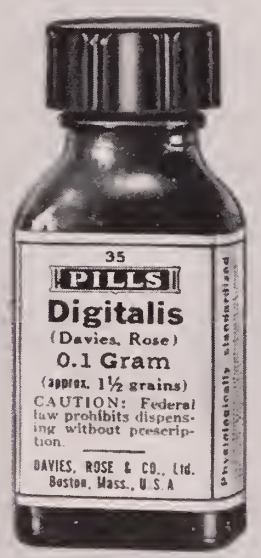

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Dr. Brunkhorst Combines Music and Medicine

Music and medicine have filled the major portion of the lifetime of *Dr. Robert Brunkhorst*, Milwaukee, who was honored by some 300 friends at a surprise testimonial dinner given at the Milwaukee Athletic Club recently. The day of the dinner a long-time friend, Thomas Melham, former Milwaukeean and past Shrine imperial potentate, flew to Milwaukee from New York. Mr. Melham lured Doctor Brunkhorst to the Athletic Club where his friends were assembled to surprise him.

ROBERT BRUNKHORST, DOCTOR AND BANDSMAN

In his UW band uniform in 1912 — As he is today at age of 69

Doctor Brunkhorst has been director of the Tripoli Shrine Band and the Milwaukee Police Band since 1940. He has been on the surgical staff of St. Joseph's Hospital for 33 years. In 1925, Doctor Brunkhorst organized the Tripoli Oriental Band and led it until 1940. He was potentate of Tripoli Shrine in 1942. In 1932 he joined the Professional Men's Symphony Orchestra and soon took over the directorship which he held until 1952. He is a past president of the Wisconsin Band Masters Association and a member of the American Band Masters Association. He also was one of the founders of the Shrine Bandmasters Association of North America and has been elected its honorary life president.

Two other interests which Doctor Brunkhorst follows closely are boxing and the Civil War. For 26 years he has been a physician for the State Athletic Commission, and he and his wife have toured the sites of the historic Civil War battles.

Biological Society Hears Dr. Lepley

Dr. Derward Lepley, Jr., Milwaukee, assistant professor of surgery, Marquette University School of Medicine, discussed heart research at a meeting of Tri Beta Biological Society of Mount Mary College April 11. Doctor Lepley is a member of the Wisconsin Heart Association, Milwaukee County Council speakers bureau, which provides speakers as part of its educational program.

Physicians Attend Mayo Course

Dr. R. J. Mathwig, Stanley, and *Drs. L. E. Powell* and *R. W. Adams*, Chetek, recently attended a course in clinical review at the Mayo Clinic in Rochester, Minn.

Series on "The Family" Given at La Crosse

Dr. C. F. Midelfort, psychiatrist with the Gundersen Clinic at La Crosse, spoke on "The Family" at a series of Sunday evening discussion meetings held April 8 through May 6 at Grace Lutheran Church in Eau Claire. Doctor Midelfort has written several books and lectured frequently on family and marital problems. On April 16 he was the guest speaker at the Luther Hospital Auxiliary meeting held in Luther Hospital Auditorium, Eau Claire.

Wisconsin Alumnus Succumbs

Dr. Earl L. Burbidge, medical director of The Upjohn Company since 1951, died April 7 while visiting his wife in a Detroit hospital. Doctor Burbidge, 55, joined Upjohn in 1947 as senior staff physician and in 1949 became medical director in charge of clinical research, moving up to his latest post two years later. A 1928 graduate of the University of Wisconsin, Doctor Burbidge was athletic director and coach in Wisconsin high schools for six years, then entered medical school at Washington University in St. Louis where he received his M.D. degree in 1939. He held memberships in the American Medical Association and the Michigan State Medical Society.

Dr. Schroeder Takes New Kenosha Post

Dr. Harold T. Schroeder, psychiatrist at Racine County Guidance Clinic and Mental Health Clinic since 1945, has resigned, possibly effective June 1, to take active direction of the newly combined Kenosha Guidance Clinic and Family Service Agency.

Dr. Eichman New Student Health Director

Dr. Peter L. Eichman, Madison, has been appointed director of student health by the University of Wisconsin Board of Regents. Beginning July 1 he will succeed *Dr. John H. Flinn* whose resignation will become effective on that date.

Dr. O. A. Sander Teaches Course

Dr. Oscar A. Sander, Milwaukee, participated as an instructor in the intensive refresher courses presented in Chicago at the 47th annual meeting of the Industrial Medical Association early in April. Nearly 2,000 occupational health specialists from all parts of the country attended the three-day meeting of allied organizations representing the physicians, nurses and dentists. The annual meetings of these three associations constitute the American Industrial Health Conference. Doctor Sander, who is clinical professor of Occupational and Environmental Medicine at Marquette University School of Medicine, received his M.D. degree from the University of Pennsylvania in 1927.

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MARKED IMPROVEMENT IN APPETITE, STRENGTH AND SENSE OF WELL-BEING

Fourteen patients, age 66 to 77, treated with Winstrol, usually in a dosage of 6 mg. daily, for various periods in order to correct underweight, weakness and chronic fatigue. Marked improvement occurred in appetite, sense of well-being and strength; almost all patients gained weight.

...for patients with osteoporosis and arthritis—
RELIEF OF PAIN, IMPROVEMENT IN MOBILITY

Twenty-one patients with arthritis treated with Winstrol for pain and limited mobility due to osteoporosis. With few exceptions, dosage was 6 mg. daily; duration of treatment varied from a few weeks to 6 months. In 8 patients relief of symptoms was excellent and in 6 moderate. Of the 7 persons in whom no relief was obtained, 5 had received treatment for less than one month and some had been given doses below 6 mg.

...for patients with malignant disease—
NOTABLE WEIGHT GAINS, INCREASED APPETITE AND SENSE OF WELL-BEING

Twenty-six patients, mostly women, weak, emaciated and seriously ill, were administered Winstrol in dosage of 6 mg. daily for periods extending up to 14 months (average 6.7 months). Notable weight gains occurred. Patients showed increased appetite, alertness and confidence, better appearance, increased mobility and tolerance to pain.

...for patients with chronic, non-malignant disorders—
IMPROVEMENT IN WEIGHT AND GENERAL ACTIVITY, INCREASED SENSE OF WELL-BEING

Eight patients with advanced tuberculosis, bronchopulmonary disease, nephritis and ulcerative colitis treated with 6 mg. of Winstrol daily for from 3 to 4 months. Gains in weight varied from 6 to 27 pounds with increased sense of well-being and improvement in general activity.

...for undernourished, underweight children and adolescents—
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One hundred and twenty children, age 1 to 11 years, underweight and in poor health, were given Winstrol for several months. Majority received daily dosage of from 2 to 4 mg. In nearly all, appetite was improved. Over 70 per cent showed significant gains in weight of from 5 to 17 pounds.

DOSAGE: Usual adult dose, one 2 mg. tablet t.i.d. just before or with meals; children from 6 to 12 years, up to 1 tablet t.i.d.; children under 6 years, ½ tablet b.i.d. Available in bottles of 100 tablets.

Complete bibliography and literature available on request. Before prescribing, consult literature for additional dosage information, possible side effects and contraindications.

*animal data

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WISCONSIN PHYSICIANS *continued*

Doctors Have Hobbies, Too

Dr. James V. Terrano, who began his medical practice in Plum City about a year ago, has entertained a good many of his patients and friends with his collection of guns. Each gun has a personal association with Doctor Terrano. Best gun in the collection, according to Doctor Terrano, is the rifle he made himself. The barrel and action were handmade and the stock was carved by hand. Doctor Terrano worked as a tool and die laborer until after the war when he decided to fulfill a lifelong ambition and study medicine. He was graduated from medical school at Chicago in 1953 and served his internship in Wheeling, W. Va.

Dr. Allin Continues Talks on Aged

Dr. Robin Allin, Madison, continues to answer steady requests for his talk on "Health Care of the Aged." On April 24 he addressed the Dane County Republican Women.

Dr. Royal Rotter Cited

Dr. Royal Rotter, Madison, has been advanced to fellowship membership in the American College of Physicians. The College, which represents more than 11,000 internists and specialists in related fields, held its 43rd meeting at Philadelphia, Pa., early in April.

Dr. Griffin Named to Board of Directors

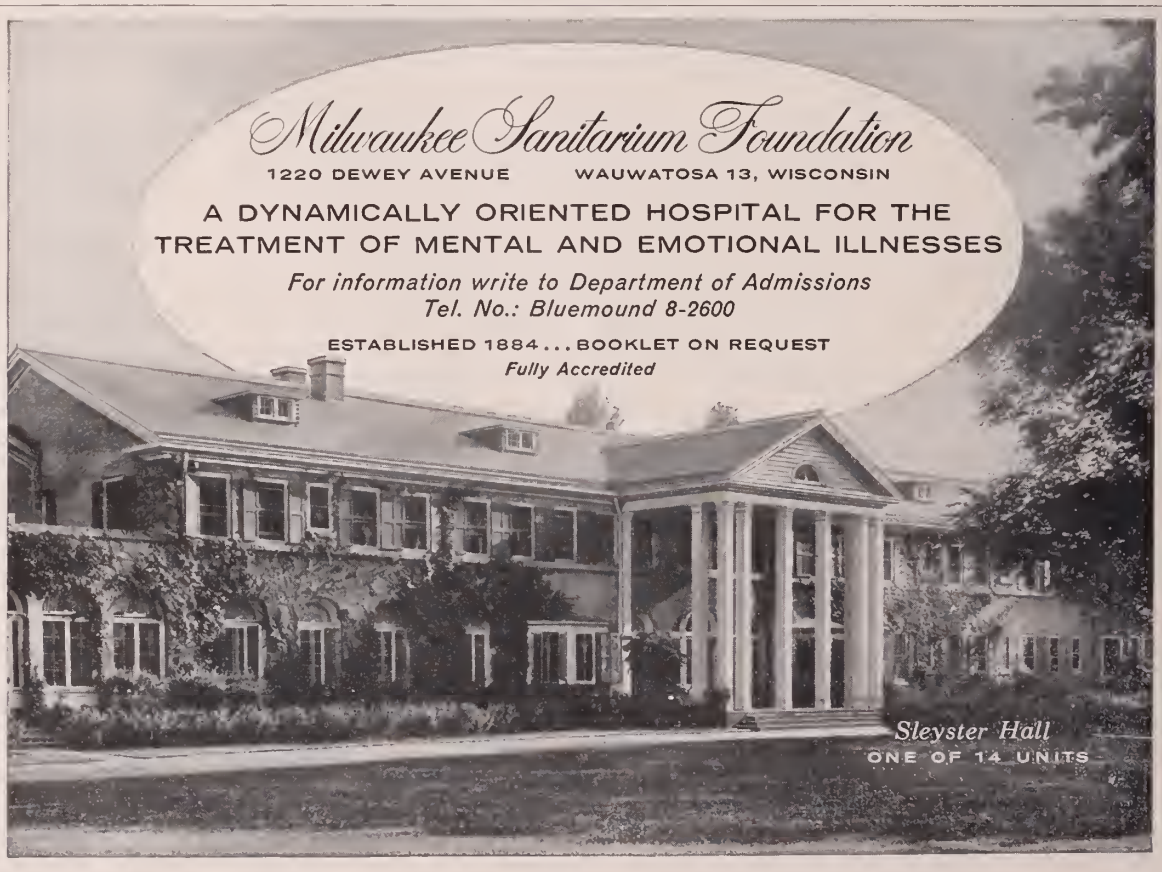
Dr. Vernon Griffin, Mauston, has been appointed a member of the board of directors of the new nonprofit Hess Memorial Hospital Association of Juneau County. The newly named board will be in charge of the construction program and upon completion will operate the new hospital.

Waukesha Doctors Attend Meeting

Dr. Ruth E. Church, medical director of the Waukesha County health department, and *Dr. Bernard J. Werra*, Waukesha, participated in key roles in discussions of community health services and the eradication of tuberculosis at the annual meeting of the Wisconsin Anti-Tuberculosis Association at Hotel Pfister, Milwaukee, April 12 and 13. Doctor Church was a member of a panel which discussed health services as outlined by Dr. Vlado A. Getting, University of Michigan School of Public Health, Lansing. Doctor Werra took part in a town meeting discussion on the concept of eradication of TB.

Doctor Zach Talks to Nurses

Dr. Robert G. Zach, Monroe radiologist, spoke on "Quackery As It Exists" to the Second District Wisconsin State Nursing Association at its meeting May 10 in Monroe. The second district includes Edgerton, Fort Atkinson, Beloit, Janesville, Lake Geneva, and Delavan.



Medical Meetings
Postgraduate Courses

American College of Gastroenterology

The annual course in postgraduate gastroenterology of the American College of Gastroenterology will be given at the Morrison Hotel in Chicago November 1–3. Moderators will be Dr. Owen H. Wangensteen, chairman of the department of surgery, University of Minnesota School of Medicine, and Dr. I. Snapper, director of medical education, Beth-El Hospital, Brooklyn, N.Y.

For further information and enrollment write to the American College of Gastroenterology, 33 West 60th Street, New York 23, N.Y.

A.M.A. Council on Occupational Health

Physicians and industrial health experts from all sections of the nation will gather in Boston October 2–3 for the 22nd Congress on Occupational Health. The two-day meeting at the Somerset Hotel will be sponsored by the American Medical Association's Council on Occupational Health.

Subjects to be discussed in scientific presentations include History and Problems of Occupational Health in New England, Small Plant Occupational Health Programs, Confidentiality of Occupational Health Records, Human Factors in Accidents, Mental and Emotional Problems in the Worker and Occupational Health and Workmen's Compensation Problems Posed by Handicapped Workers.

Additional information may be obtained by writing to the Council on Occupational Health, American Medical Association, 535 North Dearborn, Chicago 10, Ill.

National Society for Crippled Children & Adults

Representatives of 12 Caribbean countries will join leading United States rehabilitation authorities in considering treatment and education of children at the annual convention of the National Society for Crippled Children and Adults November 16–20 at the Hotel Fontainebleau, Miami Beach, Fla. Countries which will participate in a special Caribbean Rehabilitation Day are: Antigua, Columbia, Costa Rica, Cuba, Dominican Republic, El Salvador, Guatemala, Haiti, Jamaica, Mexico, Trinidad, and Venezuela.

American College of Surgeons

Annual Clinical Congress of the American College of Surgeons will be held October 15–19 in Atlantic City, N. J.

Animal Care Panel

The 13th annual meeting of the Animal Care Panel will be held at the Conrad Hilton Hotel, Chicago, October 2–5. The four-day meeting will consist of scientific sessions where papers on the care and management of animals used in biological and medical research will be presented and discussed. Demonstration sessions will run concurrently with the scientific session. Dr. Robert J. Flynn, Argonne National Laboratory, Argonne, Ill., is secretary-treasurer.

WISCONSIN CALENDAR
COMING EVENTS

1962

June 15: 15th Annual Clinical Day, Veterans Administration Hospital, Wood, and Dean's Committee, Marquette University School of Medicine.

June 15–17: Upper Peninsula of Michigan Medical Society annual meeting at Land O'Lakes.

June 19–20: Annual meeting of Wisconsin Association of Public Health, Madison.

June 24–28: AMA Annual Meeting, Chicago, Illinois.

July 27–28: SMS Council Meeting, Land o'Lakes.

Oct. 1–4: Scientific meeting of the Interstate Postgraduate Medical Assembly, Palmer House, Chicago.

Nov. 14–15: Scientific meeting of The Medical Society of Milwaukee County, Milwaukee.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

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MEDICAL MEETINGS *continued*

Fifteenth Annual Clinical Day

Veterans Administration Hospital, Wood, and the Dean's Committee of the Marquette University School of Medicine will sponsor their 15th Annual Clinical Day Saturday, June 16. Ross C. Kory, M. D., associate chief of staff at the Hospital, will modate the early morning session and Raymond R. Watson, M. D., assistant clinical professor of surgery at Marquette University School of Medicine, will moderate the second half of the morning session.

Presenting scientific papers will be Robert G. Brault, M. D.; Bruce F. Stengel, M. D.; S. Roger Hirsch, M. D.; Ernest O. Henschel, M. D.; Ruedi P. Gingrass, M. D.; Michael Bottum, M. D.; Joseph G. Schultz, D. D. S.; Jerome W. O'Hearn, M. D.; and Burton J. Friedman, M. D., all of Milwaukee.

Scientific Meetings Seattle World's Fair Area

Northwest Medicine has published a complete list of scientific meetings to be held in the Seattle area during the World's Fair. Any physician interested in having the list may contact the *Wisconsin Medical Journal*, Box 1109, Madison 1, Wis.

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MEDICAL STAFF

William L. Herner, M. D., Medical Director
John F. Wyman, M. D. — Lloyd F. Jenk, M. D.
Hubert H. Blanchard, M. D. — Richard O. Barnes, M. D.
John E. Leach, M. D. — Preston W. Thomas, M. D.

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

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Established 1903

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Letters of Interest

THANKS FOR HELP WITH EXHIBIT

To Charitable, Educational and Scientific Foundation:

I would like to extend my sincerest "Thank You" to you and the other committee members for so generously sponsoring my exhibit built around *The Marquette Medical Review*. Your support plus Dean John Hirschboeck's guidance and enthusiasm have gone far to make the entire project much less arduous.

Construction of the exhibit should be completed about the first of May at which time I shall obtain a suitable photograph which will be sent to you. If the exhibit receives a favorable reception at the Student American Medical Association Convention in Washington this May 9–12, then I will probably be looking your way for advice about the society's convention in May 1963.

Thank you again for making the exhibit a reality.

JEROME W. FONS, JR.
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Milwaukee 16, Wisconsin

(*Note:* The Foundation contributed $125 to the support of this exhibit.)

THANKS FOR FINANCIAL HELP

To SMS:

On behalf of the Marquette Chapter of the Student American Medical Association I would like to express our gratitude for the financial assistance you gave us to help defray expenses to the national convention in Washington, D. C. Two representatives were sent by the local chapter, Vincent Banner, the president-elect of the chapter, and myself. We found the convention to be a most informative and rewarding experience.

Marquette participated in a number of convention activities. Two of our senior students, Michael Dunn and Jerome Fons, entered an exhibit explaining the history and publication of the *Marquette Medical Review*. One of the surgical residents at Milwaukee County Hospital, David Trump, submitted an exhibit on the study of gastrointestinal disease.

The political aspects of the convention were not overlooked either. I was named chairman of the nominating committee for the convention. Later in the sessions Region 5 elected me regional vice-president for the 1962–63 school year. Region 5 is now the largest region in the nation representing thirteen medical schools. We are looking forward to another successful year for Marquette and Region 5.

RALPH F. SETT
Marquette Chapter, SAMA
President

(*Note:* The State Medical Society gave $200 to the Marquette Chapter of SAMA. Doctor Edgar End, Milwaukee, is the Society's advisor for the Chapter.)

THANKS FOR THE HONOR

To SMS:

May I thank you and the State Medical Society again for the delightful evening in Milwaukee. I was much impressed by the simple elegance of the citation and the dignity and style of the proceedings, and quite overcome by Doctor Middleton's presentation of the Vesalius on behalf of the Charitable, Educational and Scientific Foundation. We now have three out of four or five earliest editions of the *Fabrica*.

We are all looking forward to the time when we can give the physicians of the state, as well as our local clientele, the kind of service our collections and staff are equipped to give, had we but the room.

HELEN CRAWFORD
Librarian
University of Wisconsin
Medical School

(Note: Miss Crawford was given a Presidential citation at the annual meeting dinner of the State Medical Society, May 9, in Milwaukee.)

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County Society Proceedings

BROWN

Mr. Robert Murphy, legal counsel for the State Medical Society, analyzed the pretrial subpoena law, which was passed by the Wisconsin Legislature last year, for 44 members of the Brown County Medical Society which met in Green Bay May 3. He gave professional advice to the medical profession and pointed out that a modus vivendi is being worked out at this time between the State Bar Association and the State Medical Society.

CLARK

"Medical Management of Mass Casualties" was the subject of Dr. William McConahey of the Mayo Clinic, Rochester, Minn., when he spoke at the April meeting of the Clark County Medical Society. The Society unanimously went on record in opposition to the King-Anderson bill and *Dr. Sarah Rosekrans,* Neillsville, agreed to contact all legislators in the area.

DANE

The formal opening and special preview of the Dane County Medical Society's Health Fair replaced the regular May meeting of the Society. A future issue of the Journal will carry a complete story with pictures as soon as all material has been compiled on the Health Fair. The June meeting took the form of a dinner-dance for members and their wives at the Stoughton Country Club on June 9.

GREEN

Dr. Mark Coventry, head of an orthopedic surgery section of Mayo Clinic, Rochester, Minn., spoke on "Hip Fractures" at a scientific dinner meeting of the Green County Medical Society held at the Monroe Country Club the end of April.

JEFFERSON

Eighteen members of the Jefferson County Medical Association gathered at Chauncey's, Pipersville, April 26 to hear *Dr. F. J. Millen,* professor at Marquette University School of Medicine, Milwaukee, speak on "Headaches."

KEWAUNEE

The Kewaunee County Medical Society and the Wisconsin Heart Association jointly sponsored a rheumatic fever and congenital heart disease clinic at Algoma Memorial Hospital in April. *Dr. Mischa J. Lustok,* Milwaukee internist, and *Dr. Sherburne F. Morgan,* Milwaukee pediatrician, examined 25 patients referred to the clinic by their physicians who in turn will be notified of the findings.

MILWAUKEE

The Medical Society of Milwaukee County co-sponsored a program for physicians and hospital administrators on the coordination of agency services for the aged at the University of Wisconsin–Milwaukee May 24. *Dr. Silas M. Evans,* chairman of the Society's committee on aging and the Society's representative on the United Community Services Aging committee, served as commentator of the demonstration of agency services available in the community during hospitalization and at the time of discharge.

Other organizations sponsoring the program were United Community Services, University of Wisconsin Extension Division, Milwaukee Hospital Council and the Greater Milwaukee Dental Association.

OUTAGAMIE

In a joint meeting with the Outagamie County Dental Society at Appleton April 19, the Outagamie County Medical Society heard *Dr. Robert Samp,* Madison, medical director of the Wisconsin Division of the American Cancer Society, discuss oral cancer. A request from the League of Women Voters for support of the development of an adequate public health program for Outagamie County was endorsed. The Society also agreed to a request of the Outagamie County Pharmaceutical Association to form a joint interprofessional committee to cover problems and differences which might arise between the two groups.

POLK

The Polk County Medical Society met at St. Croix Falls in April to hear a discussion of the purpose and functions of the recently established Barron-Polk Mental Health Guidance Clinic. Speakers were *Dr. Elizabeth Kundert,* Eau Claire, temporary director of the Clinic, and David Markert, Eau Claire, clinical psychologist.

PRICE–TAYLOR

Dr. J. K. Trumbo of Wausau spoke on "Strabismus" and also showed movies of his trip to India at the April meeting of the Price-Taylor County Medical Society held at the Skyline Club in Phillips.

SAUK

"Common Problems of the Ear" was the title of the talk *Dr. R. D. Lange,* Madison, gave before the Sauk County Medical Society May 15 at the Sauk County Hospital and Home at Reedsburg.

SHEBOYGAN

The Sheboygan County Medical Society, at a quarterly meeting at Sheboygan May 3, unanimously recognized the heavy responsibility of law officers in the transportation and subsequent care of injured

Physicians whose names appear in italic are members of the State Medical Society.

AMERICAN CANCER SOCIETY WISCONSIN DIVISION

The booklet "Cancer of the Pancreas, Biliary Tract and Liver" by the University of Chicago physicians Raskin, Moseley, Kirsner and Palmer is still available through the American Cancer Society. Send for free copy by dropping a card to: American Cancer Society, Wisconsin Division, Box 1626, Madison, Wis., if you live outside of Milwaukee County. Milwaukee physicians may write to: American Cancer Society, Milwaukee Division, 728 North Jefferson St., Milwaukee 2, Wis.

COUNTY SOCIETY PROCEEDINGS *continued*

persons and adopted a procedure for suggestion to police, fire and sheriff's men in all emergency medical cases. The procedure is based on the premise of free choice of physician and the right of the injured person to have the services of his family doctor in case of emergency.

The Sheboygan Society will sponsor a meeting of the Fifth District (Ozaukee, Sheboygan, Washington, Manitowoc and Calumet counties) of the State Medical Society in August.

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Specialty Society Proceedings

Wisconsin Surgical Club

The 1962 spring tour of the Wisconsin Surgical Club took the group to the Pacific Northwest. Two days were spent with the Department of Surgery (Dr. J. E. Dunphy, chairman) at the University of Oregon Medical School in Portland. Another two days were spent with the University of Washington Medical School Department of Surgery (Dr. H. N. Harkins, chairman) at Seattle. One day the group visited in Vancouver, B.C., at Vancouver General Hospital and the University of British Columbia Medical School where Dr. A. D. McKenzie is chairman.

Members of the club who made the trip are: Drs. *J. M. King*, *C. M. Schroeder* and *C. F. Conroy*, Milwaukee; *W. S. Bump*, Rhinelander; *P. A. Midelfart*, Eau Claire; *M. G. Rice*, Stevens Point; *J. A. Killins*, Green Bay, and *L. D. Graber*, Oshkosh. Guests on the tour were Drs. *W. C. Harris*, Racine; *S. B. Harper* and *W. P. Young*, Madison; *K. E. Sauter*, Milwaukee; *George Murphy*, La Crosse; *P. R. Sholl*, Janesville; *G. R. Thuerer*, Rhinelander, and *V. S. Falk*, Edgerton.

New officers of the Wisconsin Surgical Society elected at a Milwaukee meeting on May 10 are:

President: *Dr. A. R. Curreri*, Madison
President-elect: *Dr. C. M. Schroeder*, Milwaukee
Secretary-Treasurer: *Dr. N. O. Becker*, Fond du Lac
Recorder: *Dr. S. B. Gundersen, Jr.*, La Crosse
Delegates to Council: *Dr. R. G. Wochos*, Green Bay; and *Dr. W. J. Boulanger*, Milwaukee

Wisconsin Heart Association

The 14th annual meeting and scientific sessions of the Wisconsin Heart Association were held in the Wisconsin Center at Madison June 9. Guest speakers included Dr. C. Walton Lillehei, professor of surgery, University of Minnesota, Minneapolis, and Dr. Lewis Dexter, clinical professor of medicine, Harvard University Medical School, and director, cardiovascular laboratory, Peter Bent Brigham Hospital, Boston. They presented the Malcolm F. Rogers lectures.

Other speakers were Dr. William Likoff, clinical professor of medicine and director, cardiovascular section, department of medicine, Hahneman Medical College and Hospital, Philadelphia; Dr. Earl K. Shirey, department of pediatric cardiology, Cleveland Clinic, Cleveland; and Dr. Thomas N. Janes, director of cardiovascular research, Henry Ford Hospital, Detroit.

Mrs. Lena Plaisted, professor of medical and surgical nursing rehabilitation at Boston University, was the principal speaker at the day-long session for registered nurses which ran simultaneously.

The Wisconsin Heart Association sponsored a rheumatic fever clinic at Calumet Memorial Hospital, Chilton, May 16.

Wisconsin Society of Internal Medicine

The 1962 annual meeting of the Wisconsin Society of Internal Medicine will be held at Eau Claire September 13–15.

Wisconsin Psychiatric Association

Jack Curtis, Ph.D., professor of sociology at Marquette University, was guest speaker at the annual host dinner held by the Milwaukee Sanitarium Foundation March 21 for a combined meeting of the Milwaukee Branch of the Wisconsin Psychiatric Association and the Milwaukee Neuropsychiatric Society. Doctor Curtis spoke on his findings to date and his plans for the future regarding a sociological approach to patterns of disease, especially mental disease, based on carefully planned cultural studies.

The Milwaukee Chapter was host to the Wisconsin Psychiatric Association at a meeting attended by some 65 members and their wives April 14 at the University Club, Milwaukee. Participating in a panel discussion on "Action for Mental Health," the final report of the Joint Commission on Mental Illness and Health, were *Dr. Keith Keane*, Appleton; *Dr. Leonard Ganser*, Madison; *Dr. Charles Landis*, Milwaukee; and *Dr. Leigh Roberts*, Madison.

Milwaukee Oto-Ophthalmic Society

"Newer Aspects of Biomicroscopy" were discussed by Dr. Harvey E. Thorpe, professor of ophthalmology, University of Pittsburgh, at the April 24 meeting of Milwaukee Oto-Ophthalmic Society at the University Club, Milwaukee.

The Milwaukee Oto-Ophthalmic Society held a social meeting at the University Club of Milwaukee May 22.

Wisconsin Urological Society

The Wisconsin Urological Society held its 35th annual meeting on April 13–14 at Madison. The following officers were elected for 1962–63:

President: *Dr. John P. McCann*, La Crosse
President-elect: *Dr. Anton P. Schoenenberger*, Madison
Secretary-treasurer: *Dr. John T. Hotter*, Milwaukee

Physicians whose names appear in italic are members of the State Medical Society.

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SPECIALTY SOCIETY PROCEEDINGS *continued*

Delegate to State Society: *Dr. Frank M. Hilpert,* Racine

Alternate Delegate: *Dr. Arthur J. Jacobsen,* Wood

Dr. Robert A. Garret, chief of urology, Indiana University Medical School, Indianapolis, was the guest speaker.

Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology

The Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology held a two-day meeting at University Hospitals in Madison June 9–10. A buffet luncheon for members, guests, and wives was served at the home of *Dr.* and Mrs. *Matthew D. Davis,* The Highlands, Madison.

SMS Section on Ophthalmology and Otolaryngology

New officers of the Section on Ophthalmology and Otolaryngology of the State Medical Society elected at a meeting May 10 are:

Chairman: *Dr. William C. Randolph,* Manitowoc
Secretary: *Dr. Clemens Kirchgeorg,* Neenah
Delegate: *Dr. Robert T. Schmidt,* Green Bay
Alternate: *Dr. Frank G. Treskow,* Milwaukee

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News of Wisconsin Physicians

Dr. Tenney Retires from Teaching

Although he plans to retire from his position as clinical professor at the University of Wsconsin Medical School this July, *Dr. H. Kent Tenney*, Madison, plans little change in his schedule of directing a weekly radio program and counseling parents on child-raising problems.

One of America's leading baby specialists and author of the widely read book for young mothers, "Let's Talk About Your Baby," Doctor Tenney directs the State Medical Society's "March of Medicine" radio program.

Doctor Tenney has maintained a private practice since moving to Madison in 1920 shortly after having completed his internship in the Evanston (Ill.) Hospital. He received his M.D. degree from Northwestern University in 1919 and did postgraduate work in pediatrics at Michael Reese and Children's Memorial hospitals in Chicago.

For years, Doctor Tenney has contributed greatly to the postgraduate educational program, traveling all over the state to bring doctors the latest information and techniques in pediatrics. He has been chairman of the Governor's Committee for Children and Youth, state chairman of the American Board of Pediatrics, president of the State Medical Society, chairman of the Wisconsin Mental Health Advisory Committee, and delegate to the White House Conference on Children and Youth. In 1961 he was named Mental Health Citizen of the Year.

H. K. Tenney, M.D.

C. S. Harper, M.D.

Dr. Harper Retires from Teaching

Dr. Carl Samuel Harper, Madison, pioneer in the field of obstetrics and gynecology, will retire from the University of Wisconsin Medical School this year. He was the first obstetrician and gynecologist with residency and training in his specialty in Wisconsin's capital city.

When he leaves the university, he will leave the department that he helped found in 1925 and in which he has taught for 37 years.

"His contributions to the education and literature in his specialty of obstetrics and gynecology have been outstanding. His students have benefited by his scholarly associations. His teaching showed a human nature, at times humorous, always practical," *Dr. Ralph E. Campbell*, his colleague in the department, says.

"A teacher has to work at teaching," is Doctor Harper's modest answer to the tribute.

Doctor Harper, who will continue with his private practice after he retires from teaching, is on the active staff of Madison General Hospital and the courtesy staff of Methodist Hospital, Madison.

The name of Carl Harper brings up other memories to long-time Wisconsin basketball fans. Doctor Harper was a member of the now fabled University of Wisconsin basketball team of 1911 through 1914 —the team that lost one game in three years. Doctor Harper himself never played a losing game because the one they lost—to the University of Chicago—was played when he had a sprained ankle.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Gordon Presents Paper

Dr. Edgar S. Gordon, Madison, presented a research paper at the annual meeting of the American Thyroid Association held in New Orleans May 10–13.

Dr. Mueller Goes to Italy

Dr. Gerald C. Mueller, Madison, went to Milan, Italy, early in May to speak before the International Congress on Hormonal Steroids.

Dr. Bennett Attends Texas Meeting

Dr. Maxine Bennett, Madison, attended the spring meeting of the American Otological Society and the Triological Society held recently in Dallas, Tex.

Dr. Henning Takes School Position

Dr. Roger E. Henning left Menasha in June to accept the post of health director for the Des Moines, Iowa, public school system. He has been health director for the Aid Association for Lutherans, a fraternal insurance society.

Dr. Gilbert Holds National Office

Dr. Robert L. Gilbert, La Crosse, was installed as a new trustee of the American Society of Internal Medicine at the Society's annual meeting in Philadelphia, April 6–8. A graduate of Yale University Medical School, Doctor Gilbert was a major in the Medical Corps in World War II and is presently Chief of Medicine at the Grandview Clinic Hospital, La Crosse. He is a diplomate of the American Board of Internal Medicine, a founding member of ASIM and currently its membership chairman, past

president of the Wisconsin Society of Internal Medicine, and a member of the American Diabetes Association.

New Specialists Listed

Recently examined and certified in the specialty of obstetrics and gynecology by the American Board of Obstetrics and Gynecology are the following Wisconsin physicians: *Drs. Stephen Austin, Herbert F. Sandmire* and *George J. Theiler,* Green Bay; *Edwin Barnes,* Kenosha; *Andrew Boyd, Emil J. Drvaric, William E. Finlayson, William K. Hoffman, Robert A. Holland* and *Edward J. O'Brien,* Milwaukee; *John L. Claude,* Oconomowoc; *Leo R. Grinney,* Racine; *George J. Petersen,* Appleton; and *Ralph F. Sortor,* Hales Corners.

Dave Lindberg Photo, Marshfield

Dr. George G. Stilwell of Rochester, Minn., and Dr. Stafford W. Gedge of Marshfield

Medical Writing Is Meeting Topic

Dr. George G. Stilwell, clinical pathologist at the Mayo Clinic in Rochester, Minn., and president-elect of the American Medical Writers Association, discussed "Medical Writing" at the monthly scientific meeting held in the Marshfield Clinic library April 26. *Dr. Stafford W. Gedge,* Marshfield, introduced him to the audience of about 50 medical men. Doctor Stilwell has been active in the medical publication section of the Mayo Clinic for nine years.

Dr. Emanuel Presents Paper

Dr. Dean A. Emanuel, Marshfield, presented a paper on "Cryptostroma Corcicale," a mold from which maple-bark disease develops, at the 58th annual meeting of the National Tuberculosis Association held in Miami Beach, Fla., May 20–23. Maple-bark disease is an occupational disease that had not been reported in 30 years; it previously had been reported in 35 patients in 1932. F. J. Wenzel of the Marshfield Clinic was co-author of the paper.

Dr. Niebauer on Hospital Board

Dr. W. E. Niebauer, Phillips, is the recently elected secretary of the Southern Price County Hospital board of directors.

Nuclear War Discussed by Dr. Oertley

Dr. Robert Oertley, Darlington, discussed radioactivity produced by nuclear tests in a lecture sponsored by the Commission on Christian Social Concerns recently at the First Methodist Church at Whitewater.

Certified Diplomates of Anesthesiology

Three Wisconsin physicians have been certified as diplomates of the American Board of Anesthesiology as of April 6, 1962. They are: *Dr. Delfin J. Beltran,* Wauwatosa; *Dr. David H. Gatherum,* Milwaukee; and *Dr. William E. Mateicka,* Menomonee Falls.

Talk at Mental Health Institute

Dr. Harold F. Borenz, Madison, director of the child psychiatry division, University Hospitals, and *Dr. Leigh Roberts,* Madison, University of Wisconsin Medical School, spoke at the Iowa County Mental Health Institute April 30.

Dr. Gollin Closes Office

Dr. Frank Gollin, La Farge, has closed his office after 20 years of practice in the village. For the past two years he has been doing research work in Madison and holding office hours at La Farge on Wednesday and Saturday.

Dr. Allin Debates Medical Care

Dr. Robin N. Allin, Madison, chairman of the Committee on Health Economics of American Life of the State Medical Society, spoke against the King-Anderson bill May 14. His opponent in the debate which was sponsored by the Social Action Committee and Laymen's League of the First Unitarian Society was Arthur Miles, chairman of the Wisconsin Committee for Health Insurance for the Aged through Social Security.

Build New Medical Clinic

Drs. Lars Gulbrandsen, and *David, De Verne* and *Edward Vig,* Viroqua, are building a new clinic to be known as the Viroqua Medical Building. The building should be ready for occupancy about November 1.

Dr. Lanier Speaks to Church Women

Dr. Patricia Lanier, Kewaunee, spoke at the May fellowship luncheon of the United Church Women of Manitowoc County May 4 at the Grace Congregational Church at Two Rivers. Her subject followed the theme of the day, which was "One Family Under God; Who Is My Family?" Doctor Lanier was recently appointed to the State Commission on Aging.

Speakers at Two-Day Seminar

Dr. H. Kent Tenney, Madison, chairman of the Governor's Commission on Mental Health, and *Dr. Leonard J. Ganser,* Madison, director of the State Division of Mental Hygiene, were speakers at a two-day seminar May 4–5 at St. Norbert College, Green Bay. The event was sponsored by the Brown

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WISCONSIN PHYSICIANS *continued*

County Association for Mental Health and the Division for Mental Hygiene of the State Department of Public Health.

Dr. Banyai Moderates Discussions

Dr. Andrew L. Banyai, Chicago, clinical professor of medicine, Emeritus, Marquette University School of Medicine, Milwaukee, was moderator of the panel discussions on "Management of the Cardiopulmonary Cripple," sponsored jointly by the Ohio Chapter of the American College of Chest Physicians and the Ohio State Medical Association at Columbus, Ohio, May 17, and by the Minnesota Chapter of the American College of Chest Physicians and the Minnesota State Medical Association at Minneapolis, Minn., May 21.

Dr. Orth Lauds Service

Dr. O. S. Orth, Madison, chief of staff at University Hospitals, spoke on "Pride of Accomplishment" May 9 at a recognition day party at which 34 employees were praised for long service records at University Hospitals.

Dr. Curreri Studies Manpower Needs

Dr. Anthony R. Curreri, University of Wisconsin professor of surgery, is on two weeks active duty training in the Office of the Army Surgeon General. Doctor Curreri, who holds the rank of colonel in the Army Reserve Medical Corps, is conducting a study of manpower requirements for Army surgeons with emphasis on mobilization needs.

Dr. Samp Speaks at Kenosha

Dr. Robert J. Samp, Madison, assistant professor in the department of surgery at the University of Wisconsin, was the guest speaker at the spring dinner of the Kenosha Chamber of Commerce held at the Eagles Club May 15.

Medical School Receives Grants

Federal research grants totaling 3.5 million dollars have been awarded to 21 University of Wisconsin professors by the National Institutes of Health in Washington, D.C. Among those receiving grants are *Dr. Halvor Vermund,* $50,880 cancer grant; *Dr. O. A. Mortensen,* $242,582 for research training for four years in anatomical sciences; *Dr. A. S. Evans,* $102,460 for epidemiological and microbiological research training; *Dr. O. S. Orth,* $50,000 to train students in research anesthesiology; and *Dr. D. Murray Angevine,* $20,000 for experimental pathology.

Dr. Craig Named Medical Director

Dr. James L. Craig, member of the New Richmond Clinic, has been appointed civil defense medical director for St. Croix County.

Jaycees Elect Cumberland Doctor

Dr. Robert M. Anderson of Cumberland was installed as president of the Wisconsin Junior Chamber of Commerce at the annual state convention held in Milwaukee the early part of May. Doctor Anderson, a University of Minnesota graduate, has lived with his wife and three sons in the northwestern Wisconsin community of 1,900 persons for about three years.

Dr. Blose Goes to Nebraska

Dr. I. L. Blose, Durand, closed his office June 1 and has left for the University of Nebraska Medical School in Omaha, Neb. He has been given a residency fellowship in the field of psychiatry which is supported by a grant from the National Institute of Mental Health. Doctor Blose is 1 of 20 doctors who received residency fellowships among 600 doctors across the United States who made application.

Dr. Haza Explains Heart Disease

Thilco News Photo, Kaukauna

Dr. Bernard Haza of the Medical Arts Clinic in Appleton discussed coronary heart disease at a spring meeting of the Thilmany Management Club of Kaukauna. Examining a model of a heart following his talk are C. L. Dostal, president of the Thilmany Pulp and Paper Company; Dactar Haza, who spake in behalf of the Wisconsin Heart Assaciation; Dwight Chandler, program chairman, and John Mau, club president.

Location Plans Changed

Dr. Don H. Martin, recently on the staff of the U. S. Naval Hospital in San Diego, Calif., has decided not to locate in Arcadia as previously announced.

Dr. Griffin to Head Board

Dr. Vernon Griffin, Mauston, has been elected to head the 11-member board of directors of the proposed nonprofit hospital association in Mauston.

Former Wisconsinite Wins Recognition

Dr. Chester M. Kurtz, Albuquerque, a life member of the Wisconsin Heart Association, received a gold service recognition medallion for his efforts and service to the New Mexico Heart Association. Doctor Kurtz, who was a faculty member of the University of Wisconsin's Medical School and headed the department of cardiology at University Hospitals until 1957, is currently director of the Veterans Administration Hospital in Albuquerque.

Waukesha Doctors Study Family Life

Dr. Eugene B. Frank and *Dr. W. E. Rosenkranz*, president and secretary of the Waukesha County Medical Society, met with several county officials recently to discuss medically based problems which affect family life, and means with which the community might help to cope with them.

Dr. Bouman Given International Honor

Dr. H. D. Bouman, Madison, professior of physical medicine at the University of Wisconsin Medical School, has been elected to an International Honor committee of the European Federation of Physical Medicine and Rehabilitation within the framework of the countries of the Common Market, together with other prominent physiatrists from countries all over the world.

Dr. Schilling Speaks at Munich

Dr. Robert F. Schilling, Madison, spoke at the World Congress of Gastroenterology at Munich, Germany, in May.

Dr. Waisman Attends Symposium

Dr. Harry A. Waisman, Madison, attended a symposium at The Ames Company in Elkhart, Ind., in May.

Artificial Implant Headed by Dr. Young

Dr. William P. Young, Madison, headed the team of surgeons at University Hospitals in Madison who recently performed a successful implant of an artificial heart valve in a human. The same team has to its credit some 200 cases of open heart surgery using the mechanical heart.

Dr. Shideman Takes Minnesota Post

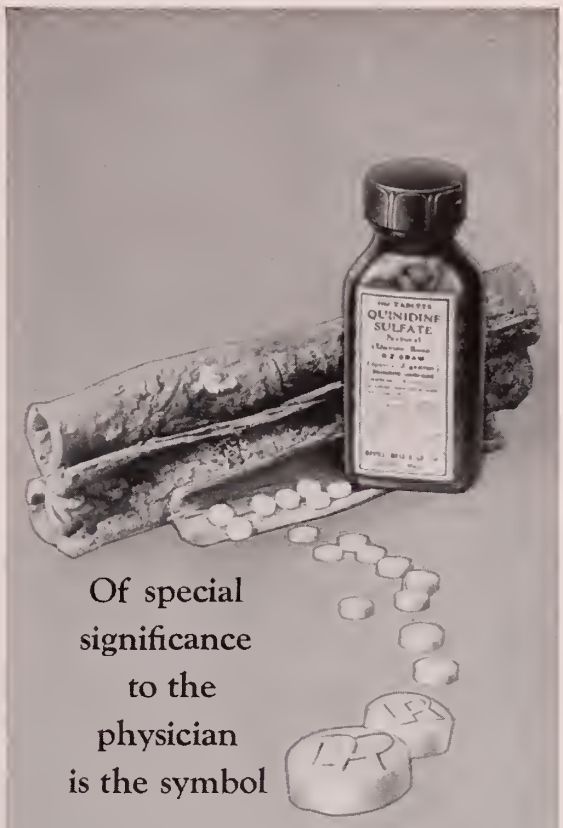
Dr. Frederick E. Shideman, chairman of the pharmacology department of the University of Wisconsin Medical School, Madison, has resigned to accept a similar position at the University of Minnesota. Doctor Shideman has been one of the co-editors of the Comments on Treatment section of the WISCONSIN MEDICAL JOURNAL.

Dr. Mickle Heads Wisconsin Optimists

Dr. Kenneth Mickle, Green Bay, was named district governor of Wisconsin Optimist Clubs at a recent convention in Manitowoc. He is a former president of the Green Bay Optimist Club.

44th General Hospital Group Trains

Col. Herman H. Shapiro, heart specialist on the staff of University Hospitals, Madison, was commander of the 44th General Hospital, U.S. Army Reserve unit affiliated with the University of Wisconsin Medical School, which saw two weeks of active training duty at Fort Riley, Kan., in June. *Lt. Col. Bruce J. Longley*, Madison, was the training officer.



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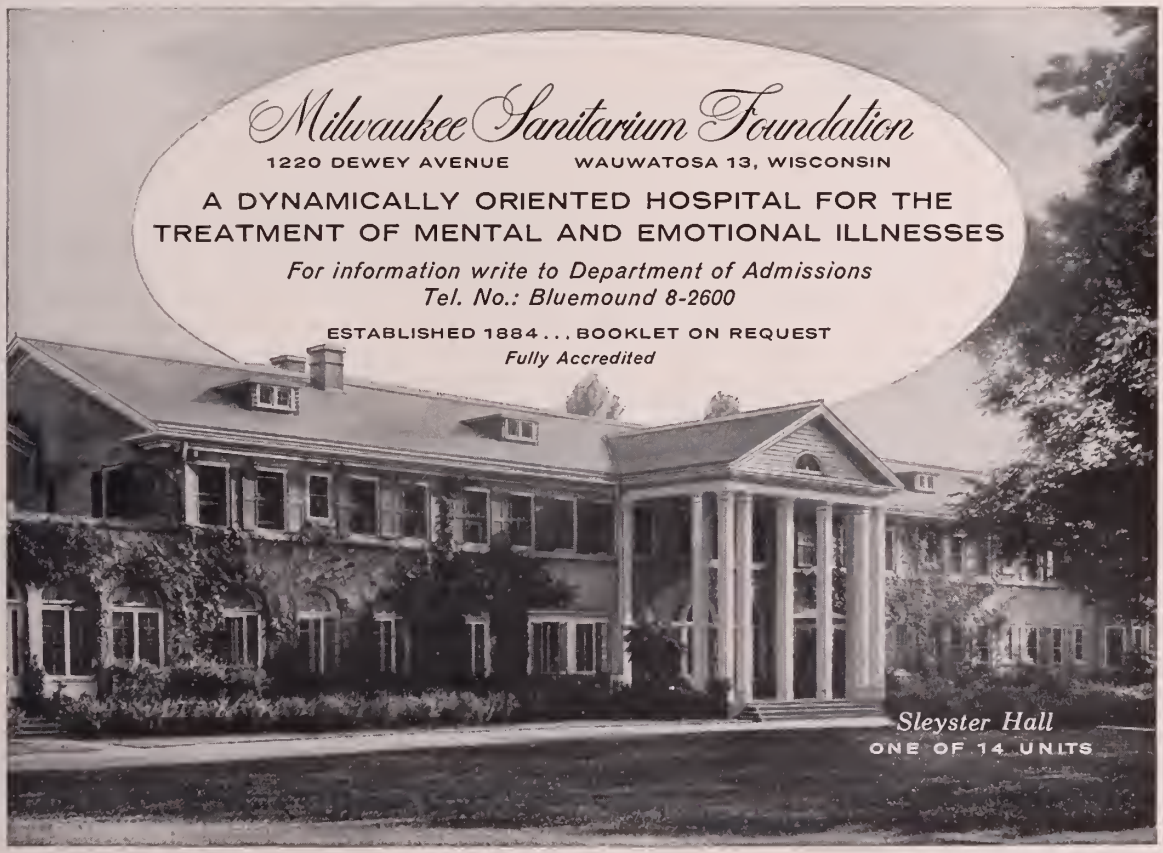
Society Records

Membership Report as of April 30, 1962

NEW MEMBERS

Jean L. Lang, 2305 Sommers Avenue, Madison 4.
Gordon E. Lang, 2305 Sommers Avenue, Madison 4.
Robert Gregor, Rogers Memorial Hospital, Oconomowoc.
Murray A. Litton, 1044 Kabel Avenue, Rhinelander.
V. Balciunas, 625 57th Street, Kenosha.
Robert L. Demke, Westfield.
John G. Telford, Washburn Hospital, Washburn.
E. Madison Paine, 9035 Watertown Plank Road, Milwaukee.
Ronald K. Wells, 949 North Glenview Avenue, Wauwautosa.
Howard W. Fiedler, 4424 North Wilson Drive, Milwaukee 11.
Joyce M. A. Eisenbraun, 620 North 19th Street, Milwaukee.
Jay P. Bartlett, 8668 North Seneca Road, Milwaukee 17.
George E. Whalen, Jr., 18045 West Burleigh, Brookfield.
Loren J. Yount, 9216 West Bluemound Road, Apt. 5, Milwaukee 13.
Stuart E. Milson, V. A. Hospital, Wood.
Marcial E. Martinez, 609 North 19th Street, Milwaukee 3.
Michael T. Jaekels, 92 Hemlock, Park Forest, Illinois.
Thomas A. Kegel, 8700 West Wisconsin Avenue, Milwaukee.
James F. Guhl, 8500 West North Avenue, Milwaukee.
Harry Chinchinian, 2942 North Marietta, Milwaukee.
John W. Bunke, 11816 Bluemound Road, Milwaukee 13.
Roland C. Brown, 161 Menlo Boulevard, San Antonio 23, Texas.
Dale H. Mann, 4455 West Bradley Road, Milwaukee.
Donna H. Larson, 7404 West Wedgewood Drive, Milwaukee.
Martin W. Kleiman, 841 North Broadway, Milwaukee 2.
Willi G. Jurczyk, 4263 West Fond du Lac Avenue, Milwaukee.
William P. Chalos, 161 West Wisconsin Avenue, Milwaukee.
Robert A. Scheidt, 2900 West Oklahoma Avenue, Milwaukee.
Robert D. Schmidt, 412 North 75th Street, Milwaukee 13.



SOCIETY RECORDS *continued*

Lawrence M. Flanary, 1411 North 116th Street, Wauwatosa.
Richard F. Mattingly, 8700 West Wisconsin Avenue, Milwaukee.
H. David Sackin, 1700 West Wisconsin Avenue, Milwaukee.
Louis J. Filiatrault, 24 West Marshall Street, Rice Lake.
Ricardo J. Alvarez, 1000 Eastern Avenue, Plymouth.
N. Peter Braun, Sheboygan Clinic, Sheboygan.

CHANGES OF ADDRESS

Bruce R. Bogost, to 4383 North 27th Street, Milwaukee.
Friedrick E. Hoelscher, to 5200 North 68th Street, Milwaukee.
Carroll R. Olson, to 7635 West Oklahoma Avenue, Milwaukee.
Walter W. Busby, to 2266 North Prospect Avenue, Milwaukee.
Zaga Kostich, to 7635 West Oklahoma Avenue, Milwaukee.
John E. Cordes, to 8300 West Oklahoma Avenue, Milwaukee.
Patrick J. Noonan, to 4872 North Newhall, Milwaukee.
M. F. Gutglass, to 836 North 12th Street, Milwaukee.
H. H. Hull, to 345 North Madison, Waupun.
K. B. Witte, to 2178 20th Avenue, Monroe.
Richard R. Davis, to 455 South Main Avenue, New Richmond.
Robert E. Flood, to 6900 North Port Washington Road, Milwaukee.
James R. Kuzdas, to 7635 West Oklahoma Avenue, Milwaukee.
Lewis Eisenberg, to 1610 North Prospect Avenue, Milwaukee.
Joseph Weinstein, to 5644 West Roosevelt Drive, Milwaukee.
L. W. Sennett, to 836 North 12th Street, Milwaukee.
D. A. Kuljis, to 1512 Washington Avenue, Two Rivers.
C. P. Reslock, to 345 North Madison, Waupun.
E. J. Sabljak, to 2903 West Oklahoma Avenue, Milwaukee 15.
Thomas Cox, to 6900 North Port Washington Road, Milwaukee.
Norvan F. Gordon, to 111 East Wisconsin Avenue, Milwaukee.
Donald Ratke, to 111 East Wisconsin Avenue, Milwaukee.
H. A. Fletcher, to 4184 North 14th Street, Milwaukee.
G. J. Hildebrand, to 304 Center Street, Sheboygan.
Marvin P. Eisenberg, Milwaukee, to 1700 Mission Street, Santa Cruz, California.
R. C. Thompson, Cumberland, to St. Croix Falls.
Roger L. Hepperla, Milwaukee, to 303 Cerloncourt Road, Fort Ord, California.
E. A. Brucker, Madison, to 1011 North Craycroft, Tucson, Arizona.
Robert G. Hansel, Milwaukee, to 440 South Church Street, Richland Center.
M. Rateb Homsi, Damascus, Syria, to 5630 North Lake Drive, Milwaukee.
*Asher L. M. Cornfield, Milwaukee, to Shepard Air Force Base, Wichita Falls, Texas.

*Military member.

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Urology, Two Weeks, October 29
Vaginal Approach to Pelvic Surgery, One Week, Sept. 10
Obstetrics, General & Surgical, Two Weeks, October 8
Gynecology, Office & Operative, Two Weeks, September 17
Proctoscopy & Sigmoidoscopy, One Week, September 10
General Practice Review, One Week, October 8
Gallbladder Surgery, 3 Days, October 8
Surgery of Hernia, 3 Days, October 11
Basic Electrocardiography, One Week, October 1
Board Review, Internal Medicine—Part I, September 10
Advances in Medicine One Week, October 15
Advances in Surgery, One Week, December 10
Blood Vessel Surgery, One Week, October 22
Board of Surgery Review, Part I, Two Weeks, November 5
Board of Surgery Review—Part II, Two Weeks, November 26
Fractures & Traumatic Surgery, Two Weeks, October 1
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Medical Meetings
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International Congress of Dermatology

Washington, D.C., will be the setting for the 12th International Congress of Dermatology September 9–15. Dr. Donald M. Pillsbury, Philadelphia, Congress president, has announced a scientific program involving more than 350 participants from 41 countries, utilizing almost every technique known to postgraduate medical education.

Core of the program will be 15 symposia designed to apply advances in basic sciences to clinical dermatology. Three teams of simultaneous translators will function throughout the five-day scientific session, enabling physicians to hear most of the offerings in either English, French, German or Spanish—the official languages of the Congress.

Surgeons to Hold Clinical Congress

The annual Clinical Congress of the American College of Surgeons is scheduled for October 15–19 at Atlantic City, N. J.

American Heart Association

The American Heart Association has scheduled six all-day programs on clinical cardiology of primary interest to the practicing physician at its annual scientific sessions October 26–28 in the Public Auditorium, Cleveland, Ohio. The clinical sessions will run simultaneously with regular scientific sessions and programs dealing with special aspects of cardiovascular research.

Registration forms, which include applications for hotel reservations, are available from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

Council on Arteriosclerosis

Immediately preceding the American Heart Association's annual scientific sessions, the Association's Council on Arteriosclerosis will hold its annual meeting in the Hotel Manger, Cleveland, Ohio. On October 24–25 approximately 50 scientific papers will be presented. The Council sessions are open to all interested individuals.

Milwaukee Medical Conference

The second Milwaukee Medical Conference will be held at the William L. Coffey Memorial Auditorium of Milwaukee County General Hospital November 14 and 15. Members of the program subcommittee are: Drs. Edwin H. Ellison, chairman, W. H. Frackelton, Robert E. Callan and William W. Engstrom.

The Milwaukee Chapter of the Wisconsin Academy of General Practice will co-sponsor the program and will seek Category I credit for specific portions of the program planned for general practitioners.

University of Colorado Postgraduate Courses

The following postgraduate courses have been scheduled by the University of Colorado Medical Center:

- Practical Applications in the Management and Rehabilitation of Arthritis, July 5–6.
- Ophthalmology, Estes Park, Colo., July 9–12.
- Dermatology for General Practitioners, July 19–21.
- Audiology Workshop, Estes Park, Colo., July 30 through August 3.
- Pediatrics—Clinical and Research Advances in Pediatrics and Child Guidance, Estes Park, Colo., August 6–10.
- Research Seminar on Fibrinolysis, September 17–19.
- Pulmonary Disease Seminar, Fitzsimons General Hospital, September 24–28.

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MEDICAL MEETINGS *continued*

For further information and detailed programs write to: The Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Ave., Denver 20, Colo.

University of Wisconsin Postgraduate Courses

A specialized symposium and two short courses, for which general practitioners may receive credit from the AAGP, will be offered by the University of Wisconsin Medical Center through the University of Wisconsin Extension Division.

CANCER CHEMOTHERAPY: A CRITICAL EVALUATION, August 23–25. Program chairmen are Dr. Fred J. Ansfield, associate professor, and Dr. James M. Price, professor, both of the cancer research division, University of Wisconsin.

The conference will review and discuss the basic mechanisms of the more successful antitumor agents plus the theoretical approach to improved chemicals against cancer. Newer approaches and techniques will be discussed from experimental-laboratory information and clinical experiences to date. Emphasis will be on solid tumors, but leukemia and lymphoma will be included.

DIAGNOSTIC AND THERAPY PROBLEMS COMMONLY OCCURRING IN GENERAL PRACTICE, October 4. Dr. Ovid O. Meyer, professor and chairman, department of medicine, University of Wisconsin Medical School, is program chairman.

SURGICAL EMERGENCIES CONFRONTING THE GENERAL PRACTITIONER, November 1. Dr. Joseph W. Gale, professor of surgery, University of Wisconsin Medical School, is program chairman.

Marquette University Postgraduate Courses

Marquette University School of Medicine has scheduled the following postgraduate courses to be given this fall at the Milwaukee County Hospital:

RECENT CONCEPTS IN RADIOLOGY, October 18–19, 9 a.m. to 5 p.m., Dr. John R. Amberg, director of course.

NONOPERATIVE THERAPY OF MALIGNANCY, November 14–15, 9 a.m. to 5 p.m., Dr. John D. Hurley, director of course.

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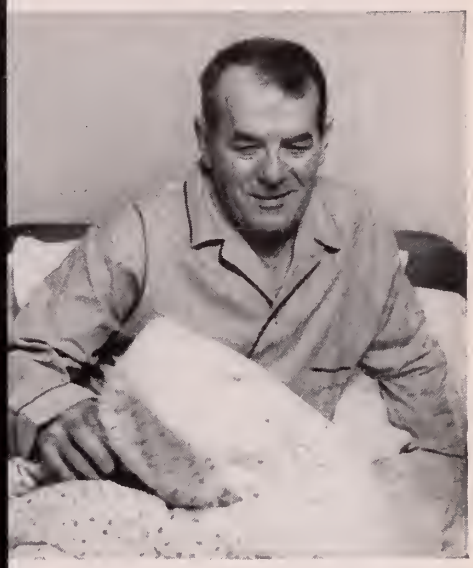
Lloyd F. Jenk, M. D.
William H. McCreary, Jr., M. D.
Preston W. Thomas, M. D.



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MEDICAL MEETINGS *continued*

American College of Physicians

BIOLOGIC FOUNDATIONS FOR THE MEDICINE OF TOMORROW, October 15–19, will be sponsored by the American College of Physicians, Dr. Karver L. Puestow, Dr. Ovid O. Meyer, and Dr. John L. Sims, University of Wisconsin Medical School, co-directors.

Fall Cancer Scrimmage at UW

CANCER SCRIMMAGE, October 20. The Eighth Annual Fall Cancer Scrimmage will be held at the University of Wisconsin Medical Center under the co-sponsorship of the Wisconsin Division of the American Cancer Society and the Cancer Research Division, Department of Surgery, University of Wisconsin Medical School. A special out-of-state cancer speaker will follow reports and papers on clinical cancer subjects from the staff of the Clinical Cancer Research section.

A noon luncheon and football game (Iowa) will complete the day. For those interested, a preview of the film of cancer which is to have its world premiere in September will be shown late Friday afternoon and evening, October 19.

Dr. R. J. Samp, University Hospitals, Department of Surgery, and Medical Director of the Wisconsin Division of the American Cancer Society, is arranging the meeting.

Scientific Meetings During Seattle World's Fair In The Seattle Area

Sept. 16–19: 73rd Annual Washington State Medical Association, Spokane.

Sept. 17–18: Annual Meeting—Washington State Society of Allergy, Spokane.

Sept. 24 & Oct. 22: Academy of General Practice, Seattle.

Aug. 8–11: American Society of Internal Medicine, Seattle.

Sept. 18: Washington State Society of Internal Medicine, Spokane.

* * *

POSTGRADUATE COURSES AT UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Aug.: Pediatric Electrocardiography.

Sept.: Management of Water, Sodium, Potassium Imbalances.

Sept.: Hand Injuries.

Fall: Surgery and Early Detection of Disease.

July 30–Aug. 3: Endocrinology and Metabolism.

* * *

Seattle Gynecological Society—Third Wednesday September and October.

Yakima Obstetrical and Gynecological Society—Last Monday—June, September, and October.

Eye Study Club, Seattle—June 25, July 23, August 27, September 24, and October 22.

Seattle Pediatric Society—Third Friday—April–September.

Washington State Society of Pediatrics—September.

Washington State Radiological Society—September 24 and October 22.

Seattle Surgical Society—Last Monday—August and September.

CALENDAR OF MEETINGS

Wisconsin

1962

July 27–28: SMS Council Meeting, Land O' Lakes.

Aug. 15–17: (Tentative) SMS Circuit Teaching Programs, Marinette (15th), Antigo (16th), Rice Lake (17th).

Aug. 23–25: Postgraduate Course on Cancer Chemotherapy, University of Wisconsin Medical School, Madison.

Aug. 25: Eli Lilly Symposium, Wisconsin Academy of General Practice, Land O'Lakes.

Sept. 12–14: Aviation Medical Service Seminar, University of Wisconsin Medical School, Madison.

Sept. 18–20: Wisconsin Academy of General Practice, Milwaukee.

Oct. 4: Postgraduate Course on Diagnostic and Therapy Problems Commonly Occurring in General Practice, University of Wisconsin Medical School, Madison.

Oct. 15–19: Postgraduate Course on Biologic Foundations for the Medicine of Tomorrow, American College of Physicians, University of Wisconsin, Madison.

Oct. 18–19: Postgraduate Course on Recent Concepts in Radiology, Marquette University School of Medicine, Milwaukee.

Oct. 20: Cancer Scrimmage, UW, Madison.

Oct. 23–25: (Tentative) Conferences on "Strokes—What Can We Do About Them?" Sheboygan (23rd), Wausau (24th), Eau Claire (25th).

Nov. 1: Postgraduate Course on Surgical Emergencies Confronting the General Practitioner, University of Wisconsin Medical School, Madison.

Nov. 14–15: Scientific meeting of The Medical Society of Milwaukee County, Milwaukee.

Nov. 14–15: Postgraduate Course on the Nonoperative Therapy of Malignancy, Marquette University School of Medicine, Milwaukee.

Out-of-State

July 23–27: Postgraduate Course on Cardiopulmonary Problems in Children, American College of Chest Physicians and the American Academy of Pediatrics, Edgewater Beach Hotel, Chicago.

Aug. 29: Medical Society Executives Association Institute, Drake Hotel, Chicago.

Aug. 30–31: AMA Institute, Drake Hotel, Chicago.

Sept. 9–15: International Congress of Dermatology, Washington, D. C.

Sept. 17–20: American Hospital Association Annual Meeting, Chicago.

Oct. 1–4: Scientific meeting of the Interstate Postgraduate Medical Assembly, Palmer House, Chicago.

Oct. 15–19: Clinical Congress of American College of Surgeons, Atlantic City, N. J.

Oct. 26–28: Annual Scientific Sessions of American Heart Association, Public Auditorium, Cleveland, Ohio.

Nov. 1–3: Annual Course in Postgraduate Gastroenterology of the American College of Gastroenterology, Morrison Hotel, Chicago.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

NEW BOOKS RECEIVED

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

BASIC ANXIETY

A New Psycho-biological Concept. By Walter J. Garre, M.D., Chief of Psychiatry, Veterans Administration Hospital, San Francisco, Calif. Philosophical Library, Inc., New York, 1962. 123 pages. Price: $5.00.

SHOCK

Pathogenesis and Therapy. CIBA International Symposium, Stockholm, June 27–30, 1961. Edited by K. D. Bock, Basle, with 120 figures. Springer-Verlag, Berlin, Gottingen, Heidelberg, 1962. 387 pages.

RENAL BIOPSY

Clinical and Pathological Significance. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P., and Margaret P. Cameron, M.A., with 134 illustrations. Little, Brown and Company, Boston, 1962. 395 pages. Price: $10.50.

SURGERY OF THE AMBULATORY CHILD

By S. Frank Redo, M.D., Surgeon in charge of Pediatric Surgery, Department of Surgery, The New York Hospital; Associate Attending Surgeon, The New York Hospital; Assistant Professor of Surgery, Cornell University Medical College. Appleton-Century-Crofts, Inc., New York. 340 pages.

INTERNAL MEDICINE IN WORLD WAR II

Volume I—Activities of Medical Consultants. Prepared and published under the direction of Lt. Gen. Leonard D. Heaton, Surgeon General, United States Army; Col. John Boyd Coates, Jr., MC, Editor in Chief; W. Paul Havens, Jr., M.D., Editor for Internal Medicine. Office of the Surgeon General, Department of the Army, Washington, D. C., 1961. 880 pages.

CURRENT GASTROENTEROLOGY

Edited by Gordon McHardy, M.D., Clinical Professor of Medicine, Louisiana State University School of Medicine, Paul B. Hoeber, Inc., Medical Division of Harper & Brothers, New York, 1962. 674 pages. Price: $16.50.

EARLY DETECTION AND DIAGNOSIS OF CANCER

By Walter E. O'Donnell, M.D., Emerson Day, M.D., F.A.C.P., and Louis Venet, M.D., F.A.C.S., with 82 figures and 3 color plates. The C. V. Mosby Company, St. Louis, 1962. Price: $12.00.

THE MECHANISM OF ACTION OF WATER-SOLUBLE VITAMINS

Ciba Foundation Symposium. Edited by A.V.S. de Reuck, M.Sc., D.I.C., A.R.C.S., and Maeve O'Connor, B.A., with 34 illustrations. Little, Brown and Company, Boston, 1962. 120 pages. Price: $2.50.

NEW AND NONOFFICIAL DRUGS 1962

An Annual Compilation of Available Information on Drugs, Including Their Therapeutic, Prophylactic and Diagnostic Status, as Evaluated by the Council on Drugs of the American Medical Association. J. B. Lippincott Company, Philadelphia and Montreal, 1962. 900 pages.

EXECUTIVES' HEALTH SECRETS

How to Lick Tensions and Pressures. By William P. Shepard, M.D., former medical director of the Metropolitan Life Insurance Co. Bobbs–Merrill Co., Inc., 1961. 268 pages. Price: $4.95.

HEALTH EDUCATION

By Bernice R. Moss, Ed.D., Professor of Health Education. University of Utah, Editor; Warren H. Southworth, Dr. P. H., Professor of Health Education, University of Wisconsin, Associate Editor; and John Lester Reichart, M.D., Chicago, Illinois, Associate Editor. National Education Association of the U. S., Washington, D. C., 1961. 429 pages. Price: $5.00.

A TRAVELER'S GUIDE TO GOOD HEALTH

The do's and don'ts of staying healthy while seeing the world. By Colter Rule, M.D. Doubleday & Co., Inc., Garden City, New York, 1960. 240 pages. Price: 95¢.

QUINONES IN ELECTRON TRANSPORT

Ciba Foundation Symposium. By G. E. W. Wolstenholme, O.B.E., M.A., M.D., M.R.C.P.; and Cecilia M. O'Connor, B.Sc. Little, Brown & Co., Boston, Massachusetts. Price: $11.00.

TRAITOR WITHIN: OUR SUICIDE PROBLEM

By Edward Robb Ellis and George N. Allen. Doubleday & Co., Inc., Garden City, New York. 237 pages. Price: $3.95.

THIRTEENTH INTERNATIONAL CONGRESS ON OCCUPATIONAL HEALTH

U. S. Executive Committee of the Thirteenth International Congress on Occupational Health, 1961. 1005 pages.

PUBLIC HEALTH FOR RELUCTANT COMMUNITIES

An Anthropological Interpretation of Community Health for the Laity, by James G. Roney, Jr., M.D., Ph.D., M.P.H., Fellow of the American Association for the Advancement of Science, Fellow of the American College of Preventive Medicine, Fellow of the American Public Health Association, Fellow of the American Anthropological Association. New York, 1961. 71 pages.

THE NATURE OF SLEEP

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. Sponsored by Ciba. Little, Brown and Co., Boston, Mass., 416 pages. Price: $10.00.

BOOKSHELF *continued*

THE DYNASTY

A medical novel by Charles Knickerbocker. Doubleday & Co., Inc., Garden City, N. Y., 1962. 416 pages.

NEW AND NONOFFICIAL DRUGS 1961

Evaluated by A.M.A. Council on Drugs. J. B. Lippincott Co., Philadelphia and Montreal, 1961. 849 pages.

PROBLEMS OF PULMONARY CIRCULATION

Edited by A. V. S. de Reuck, M.Sc., D.I.C., A.R.C.S. and Maeve O'Connor, B.A. Sponsored by Ciba. Little, Brown & Co., Boston, Mass., 1961. 96 pages. Price: $2.50.

PROGESTERONE AND THE DEFENCE MECHANISM OF PREGNANCY

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Margaret P. Cameron, M.A. Sponsored by Ciba. Little, Brown and Co., Boston, Mass., 108 pages.

BIOLOGICAL ACTIVITY OF THE LEUCOCYTE

Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Maeve O'Connor, B.A. Sponsored by Ciba. Little, Brown and Co., Boston, Mass. 120 pages.

STRONG MEDICINE

By Blake F. Donaldson, M.D. Doubleday & Co., Inc., Garden City, N. Y., 1962. 245 pages. Price: $3.95.

IRRITATION AND COUNTER-IRRITATION

By Adolphe D. Jonas, M.D. Vantage Press, Inc., New York, N. Y., 1962. 368 pages. Price: $7.50.

THE ABORTIONIST

By Dr. X as told to Lucy Freeman, Doubleday & Co., Inc., Garden City, N. Y., 1962. 216 pages. Price: $3.95.

BOOK REVIEWS

LIGHT COAGULATION

By Gerd Meyer-Schwickerath, M.D., Chief Municipal Eye Clinic, Essen; Professor of Ophthalmology, University of Bonn. Translated by Stephen M. Drance, M.B., F.R.C.S. (Eng.), Associate Professor of Ophthalmology, University of Saskatchewan, Saskatoon, Canada. With 55 figures, including 7 in color. C. V. Mosby Co., St. Louis, Mo., 1960.

Doctor Drance has performed a valuable service in translating Meyer-Schwickerath's classic, *Light Coagulation*, into English. The book begins with theoretical and historical comments concerning the background of light coagulation and then goes on to discuss in detail the use of the Zeiss Light Coagulator. The various indications for light coagulation and Meyer-Schwickerath's experience with its use are carefully outlined.

The early enthusiasm regarding light coagulation as a means of treating retinal detachment has largely abated and it is now well recognized by all authorities that light coagulation cannot be carried out unless the retina is in contact with the pigment epithelium. This limits the use of light coagulation in the treatment of retinal detachment to very favorable cases which flatten out completely with bed rest or to combined use with some sort of scleral buckling surgery in which the pigment epithelium and choroid are pushed in against the retina. In the latter situation it is usually simpler to use diathermy, although there are occasional exceptions, particularly in reoperations.

This leaves, as of the moment, the chief indications for light coagulation in the treatment of retinal tears without detachment and in the treatment of tumors in the fundus. Very few statistics are available regarding the natural course of retinal tears without detachment. It is the reviewer's opinion that the vast majority of such cases never go on to actual retinal detachment and do not require prophylactic treatment.

A special type of retinal break without detachment is the macular hole. Although treatment of the macular hole was one of the chief stimuli for development of the light coagulator, and although Meyer-Schwickerath still uses it for this purpose rather extensively, most authorities in this country agree that most macular "holes" are not true holes and should not be treated with either light coagulation or any other type of diathermy. Only when a macular hole is accompanied by detachment which fails to become reattached after adequate treatment of all peripheral breaks present, should the macular hole be treated.

It is in the area of treatment of tumors of the fundus that light coagulation currently makes its greatest contribution. Light coagulation now seems to be the treatment of choice in most cases of Von Hippel's angiomatosis and other types of retinal vascular tumors. Light coagulation has a definite place in the treatment of retinoblastoma, although Reese's method of radiation and chemotherapy with TEM seems still to be the initial treatment of choice. Meyer-Schwickerath's data on the treatment of malignant melanoma, although still small in volume, are most stimulating and interesting.

This volume, now available in English, will be an essential one for all ophthalmologists who use the Zeiss Light Coagulator, will be of great interest to all ophthalmologists who treat retinal detachment, and is well worth reading by every ophthalmologist.
—MATTHEW D. DAVIS, M.D.

MASTER YOUR TENSIONS

And Enjoy Living Again, by George Stevenson, M.D. and Harry Milt. Prentice Hall, Inc., Englewood Cliffs, N.J., 1959. 241 pages.

Plain spoken and straight forward, the style of this 241-page book is obviously the product of a professional writer who has taken the opinions of a

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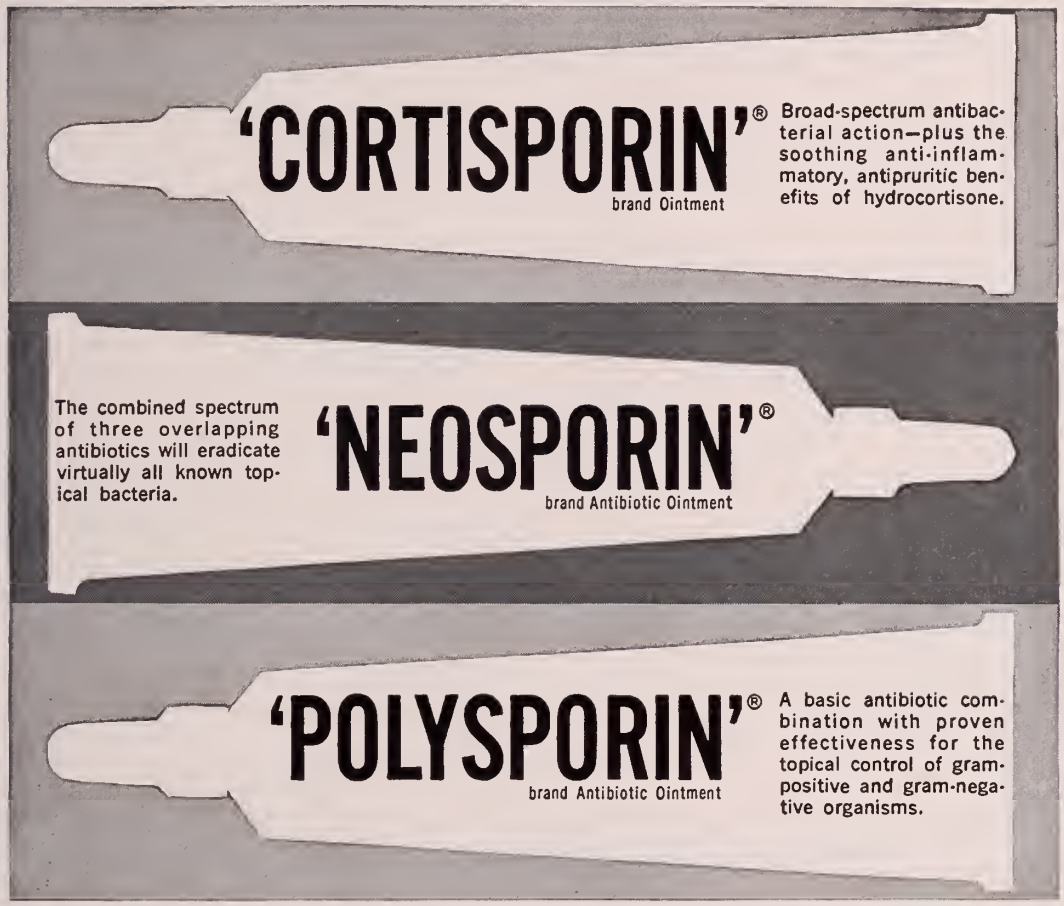

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professional psychiatrist and compiled them into a most readable and understandable book. It does not partake of the failings of the customary "cook book" type of advice giving short course to a complete psychoanalysis which gluts the market from time to time with superficial aspects of a most profound subject. The first chapter, dealing with this "shook up" age, carried in it an often quoted anecdote on pressures that one day can bring, typifying the overburdened commuter with a burden of misunderstanding in a bureaucracy similar to what many of us know too well. The remainder of the book is divided into three parts: the first, describing tension; the second, outlining eight methods for getting rid of tension; and the third, giving simple avoidance techniques to reduce tension building situations. It is noteworthy that this book does not go into diagnostics or entities of psychiatry. It is not a book of jargon nor a book of treatment in the sense of specifics or techniques or the classical sophistication of involved psychotherapy. It is just what it says it is—a request to master your tensions and methods of approach to enjoy your living again.

In this sense, it becomes a book which is designed to develop appreciation and insight, and it also, of course, carries the failures and foibles of any type of insightful therapy methodology.

There are many questions answered here such as those asked of the general physician by his patients: "What kind of a person should I see for psychotherapy? What kind of a person would be able to help me in understanding and managing my tensions?" The seven points brought forth in the chapter entitled "Talk It Out" could well be memorized by all physicians. The counsellor, clergyman, neighborhood worker, social worker and physician all could appreciate the elements of the eight methods of getting rid of tension.

Another segment of the book is devoted to children. The famous work of Dr. René Spitz, in which he taught nurses and attendants of homes for foundlings to "mother" their orphans with remarkable improvement in health and stability, is described and its manifestations carried out in a beautifully explained manner. Some comparisons might be drawn from this with Harry Harlow's work with monkeys and surrogate mothers of wire mesh and terry cloth and those which were heated with hot water bottles to simulate the warmth of animal contact. Much of the chapters dealing with children and the discipline of children are similar in character to the work of Dorothy Baruch which certainly would bear repetition well.

Unfortunately only one rather short chapter is devoted to the problems of marriage and common sense. This almost paints the book with oversimplification of this tremendous problem. Again, however, the book is not devoted to deep solutions. It is a superficial, insightful survey course on the effect of tensions upon all facets of our life from childhood through marriage. There is nothing of real content on the geriatric problem and it is, of course, illogical to expect that a small book should cover all aspects of life from birth to death.

In my experience it has been interesting to note the number of pediatricians, general practitioners and clergymen who have used this book as a source book for extending their discussions with their patients. The book is easily readable, very understandable, filled with anecdotes and interest items, and doesn't get off into controversial issues. In its simplicity it contributes to an area of education popularly confused entirely with sex.

—B. H. Glover, M.D.

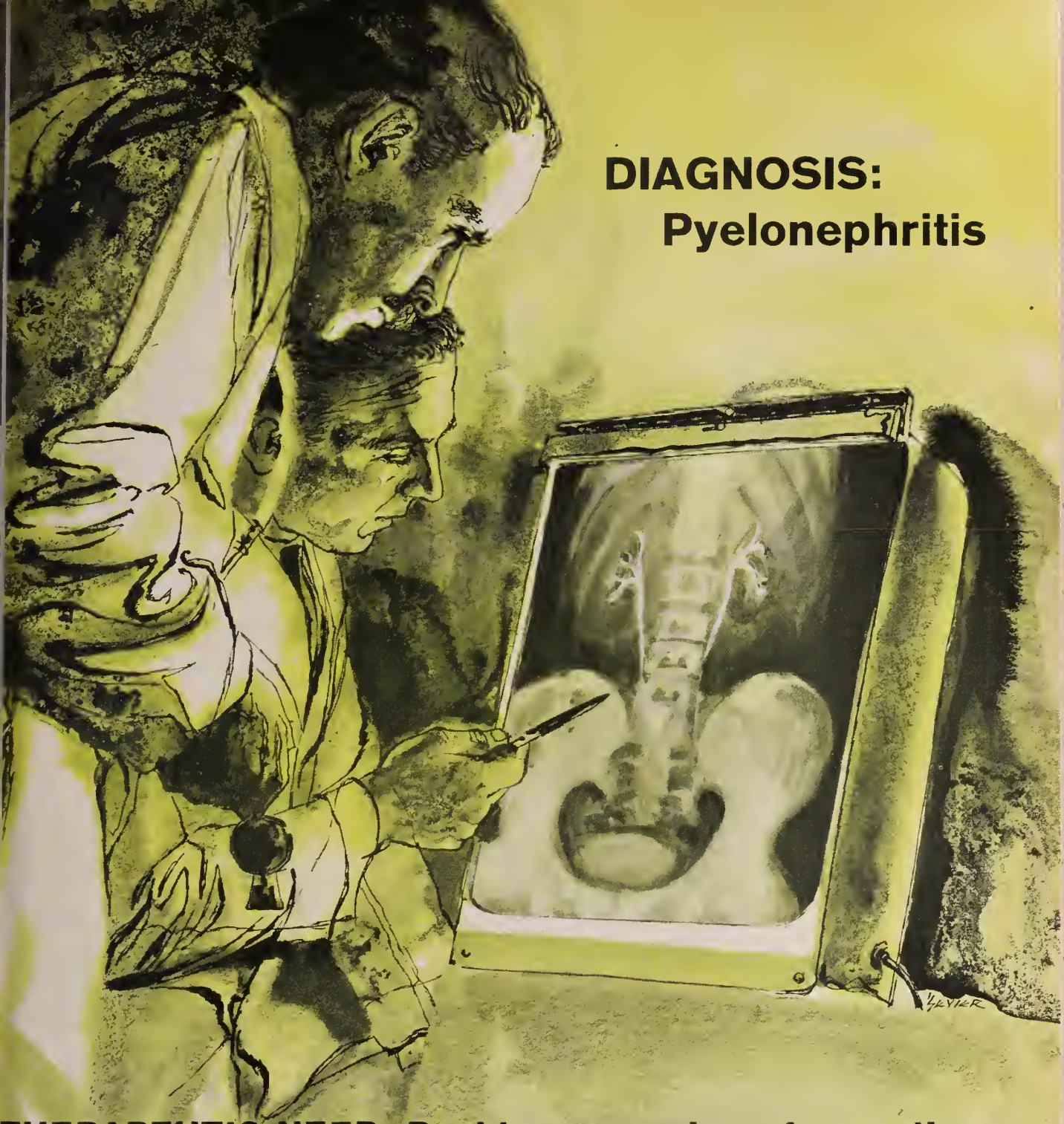
ANATOMY OF THE HUMAN BODY

By Henry Gray, F.R.S. Twenty-seventh Edition, edited by Charles Mayo Goss, M.D., Managing Editor of the Anatomical Record; Professor of Anatomy, Louisiana State University School of Medicine, New Orleans, La. Gray's Anatomy Centennial Edition, 1859–1959. Lea & Febiger, Philadelphia, Pa., 1959. 1,458 pages. Price: $17.50.

The American publishers of Gray's Anatomy had to cut their customary 6-year interval between editions by 1 year to publish the 27th edition in celebration of their centennial year of this book. The new edition is reduced by only 26 pages and 23 figures from the previous edition, but has 94 fewer figures than the 25th edition, so we see the trend continues to be for reduction in size. On the whole, the trend has been to replace many of the more diagramatic line drawings with more comprehensive and far superior half-tone drawings from European atlases.

One of the obvious features of this edition is the position of the embryology of each system at the beginning of the chapter, and according to some logic of the editor which escapes me, the histology is placed at the end of the chapter. The histology of all the connective tissues is placed with the histology section of the chapter on osteology, putting it before the discussion on ossification and the chapter on joints and ligaments which is more logical than placing it in the chapter on muscles. The embryology of the much revised cardiovascular section has been split to conform with the division into chapters on the heart, arteries, veins and lymphatic rather than describing the embryology of the entire cardiovascular system as was done previously.

In rewriting the chapter on the nervous system in order to simplify it, the author was most successful in his purpose to reduce the volume of the book. Four illustrations of typical frontal sections through the cerebral hemisphere were replaced by more detailed illustrations of sections of the basal part of the brain only. It is too bad this trend of substituting more detailed and advanced material for simple fundamentals is becoming more rampant. These new illustrations are erroneously labeled "frontal" sections, since they are cut in the plane of Meynert. When one sees the absence of a review of such basic work as that of Weddell, he realizes the necessity



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of having a number of people write on the subject with which each is familiar. One person cannot possibly be able to read, let alone evaluate, this plethora of papers flooding our journals. The discussions on muscle movements and fascial descriptions are the same old hand-me-downs of previous editions, but this is all that is available to the editors. With all the contradictions and error existing on these subjects it is obvious that it is not sufficient to take a new look at pelvic fascia, etc., but that a different look with better and more valid methods and criteria is needed to study these problems.

When the various chapters are reviewed by people acquainted with the various subjects, it might be worth discussing the value of retaining the histology and embryology sections of this book, but since there is now only one person to edit the whole book there is no reason for keeping these sections. He says he retains them at the behest of his students, yet labels on old plates have not been changed to conform to the new Paris nomenclature used in the text. I'm sure students are much alike everywhere, and that they all find these discrepancies as disconcerting as ours. Many new regional anatomy texts are now appearing, but it seems that where a detailed reference book is needed by the practicing physician it can best be done using the systemic approach as in this book. This book has also been found to be useful to those in the ancillary professions of physical therapy and occupational therapy. —Edward P. Maibenco, Ph.D.

SYPHILIS

Modern Diagnosis and Management. U. S. Department of Health, Education, and Welfare, Public Health Service Publication No. 743 U. S. Government Printing Office, Washington, D. C., 1960. Sold by Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. 63 pages. Price: $2.00.

This is an excellent presentation of the necessary information for the diagnosis and treatment of syphilis. It is a book which should be in the library of all recent graduates since they are the ones who have not had the opportunity for experience either with clinical syphilis or the treatment of the disease. Listed with each stage of syphilis is a small, quick reference summary indicating the diagnostic points and the proper treatment.

Especially valuable is the explanation of the serologic reactions which conveniently divides the types of reactions into nontreponemal antigen tests and treponemal antigen tests and indicates the significance and importance of each.

Chapter 10, which discusses some of the special problems of modern diagnosis and treatment, is particularly valuable. There is a good discussion of the false biological reaction. It also gives indications as to when to retreat patients.

The appendix includes excellent colored photographs of the various lesions of syphilis from the chancre stage to gummas and Charcot joints.

The authors are to be congratulated for achieving so much in so few pages.—Garrett A. Cooper, M.D.

NEW AND NONOFFICIAL DRUGS

An Annual Compilation. Evaluated by the Council on Drugs of the American Medical Association, 1960. J. B. Lippincott Co., Philadelphia, Pa. 1960. 768 pages.

The 1960 edition of *New and Nonofficial Drugs* once again adds a valuable reference text on drugs for use in the diagnosis, prevention, or treatment of disease. The listing of these drugs does not necessarily indicate that their usefulness has been established.

Each group of monographs is preceded by general discussion of the therapeutic action of that particular group. This gives broad general consideration to the group and then each drug is listed according to its recognized nonproprietary name or names; in addition to this the commercial name of the various preparations that are marketed in the United States are also listed. This makes it a convenient cross reference. Also included under each monograph are the chemical or biological identity, pertinent properties, actions and uses, comparisons with related drugs, its limitations, side effects, toxicity, contraindications or precautions, dose, and routes of administration along with preparations and the available sizes or strengths.

This has become a convenient text and one which can be used knowing that the inclusion of a drug in it was not determined merely for advertising purposes but that the available evidence had been submitted to the Council on Drugs of the American Medical Association and had been examined and evaluated by them. In general the Council tends to consider only the evaluation of drugs with a single active ingredient or extract from a single source. On occasion combinations or mixtures containing two or more active ingredients may receive consideration.

It is interesting to note that the 1960 edition of the N.N.D. has added 45 monographs to its edition this year and has deleted 13 monographs due to the fact that the drugs previously described are no longer commercially available in the United States. Also deleted are 8 additional items that have appeared in previous editions of the N.N.D. but have now been omitted because they are considered to be well-known formulations and have been included in the N.N.D., U.S.P. or N.F. for a cumulative period of 20 years. This group would include such well-known drugs as diphenylhydantoin sodium U.S.P., thiopental sodium U.S.P. The reviewer feels that the addition of the N.N.D. to any library is a valuable asset and it will provide a ready reference not only for physicians but other allied medical fields. —W. J. Durant

the Wisconsin Medical Journal

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Specialty Society Proceedings

Wisconsin Psychiatric Association

Northern Branch

New officers of the Northern Branch of the Wisconsin Psychiatric Association elected in June at Appleton are:

President: *Dr. Carl Kline*, Wausau
President-elect: *Dr. Albert Lorenz*, Eau Claire
Secretary: *Dr. William Heywood*, Marshfield
Treasurer: *Dr. John Petersik*, Oshkosh

Wisconsin Association for Public Health

A seminar on viral hepatitis, chief cause of yellow jaundice, was presented at the annual meeting of the Wisconsin Association for Public Health held in the Memorial Union theater at the University of Wisconsin, Madison, June 20. The seminar was one of a series offered this year to state public health associations by the Communicable Disease Center, U. S. Public Health Service, Atlanta, Ga.

Recognized by public health authorities as a growing problem, hepatitis cases numbered an estimated 73,000 in the United States in 1961, with Wisconsin reporting 403 cases.

Wisconsin Academy of General Practice

Eau Claire Leader Photo

Participating in a one-day Symposium on Medicine for Tomorrow, sponsored by the Wisconsin Academy of General Practice at Eau Claire in June, were, from left to right, *Dr. R. R. Richards*, Eau Claire, local chairman; *Dr. Edgar End*, Wauwatosa, speaker; Dr. Hugh A. Johnsan, Rockford, Ill., speaker; Dr. Raymond V. Randall, Rochester, Minn.; *Dr. Albert A. Larenz*, Eau Claire, speaker, and *Dr. P. J. Finucane*, Eau Claire, moderator.

Dr. J. D. Brown, Sparta, and *Dr. E. P. Rohde*, Galesville, were co-chairmen of the medical symposium sponsored by the Wisconsin Academy of General Practice at Sparta July 12. Speakers included Dr. J. G. Love, Rochester, Mayo Clinic neurologist, who spoke on "Backache"; Dr. R. A. Good, Minneapolis, who discussed "Immunology"; *Dr. M. J. Ciccantelli*, Milwaukee, assistant clinical professor of medicine at Marquette University, whose subject was "Rheumatoid Disease"; and *Dr. R. S. Monk*, Waukesha, who reviewed hernias. *Dr. Lou R. Schmidt*, president of the Sparta chapter, moderated an evening discussion period.

Wisconsin Division, American Cancer Society

Pierce County Unit

The Pierce county unit of the Wisconsin Division of the American Cancer Society heard *Dr. Paul S. Haskins*, River Falls, discuss the relationship between virus diseases and cancer at its June 12 meeting at River Falls.

Dairyland Chapter

The Dairyland Chapter of the WAGP and the Victory Memorial hospital staff, Stanley, heard *Dr. Thomas Kilkenny*, Eau Claire, talk on "Congenital Dislocation of the Hip in Newborns" in June.

Wisconsin Society of Internal Medicine

The 1962 annual meeting and scientific program of the Wisconsin Society of Internal Medicine will be held at Eau Claire, Sept. 14 and 15, Leslie G. Kindschi, M.D., Monroe, Society president announced.

The scientific program will include sessions on "Current Problems of Endocrinology and Pathologic Physiology," and a postgraduate course on cardiovascular disease. The scientific program will be held on Friday, Sept. 14, the postgraduate course on Saturday, Sept. 15. The Society's annual meeting and banquet will be held on Friday evening.

George E. Gutmann, M.D., Janesville, is chairman of the program committee. John H. Wishart, M.D., Eau Claire, is chairman for local arrangements.

Jerome Conn, M.D., professor of medicine, University of Michigan Medical Center, Ann Arbor, Mich., will present the annual William S. Middleton Lecture. His topic will be "Primary Aldosteronism."

August Derleth, noted Wisconsin historian and author from Sauk City, will be the featured speaker during the banquet program. Warren K. Simmons, M.D., Rhinelander, will be installed as president during the meeting.

The scientific program and postgraduate course are open to any interested physician, resident or intern. There is no registration fee. A copy of the program is available on request to the Society's executive office, 757 N. Broadway St., Milwaukee 2, Wis.

Physicians whose names appear in italic are members of the State Medical Society.

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News of Wisconsin Physicians

Dr. Kulkoski Takes Alaskan Cruise

Dr. Bernard Kulkoski, Green Bay, was among 36 members of the Flying Physicians' Association who made a 1,500 mile flight from Edmonton, Canada, to Anchorage, Alaska, this summer. Doctor Kulkoski made the trip to Edmonton from Green Bay and back to Green Bay, via Seattle, in his own light plane.

Main purpose of the mass flight of doctor-pilots over the wilderness route of the Alcan Highway was the study of disaster techniques, especially the quick and efficient movement of trained medical personnel and supplies to isolated locations. At Anchorage they convened for the annual three-day medical meeting of the Flying Physicians Association where aviation medicine, air safety, pilot competence and other pertinent subjects were on the speaking agenda.

Dr. Allin Speaks to Service Clubs

Dr. Robin Allin, chairman of the State Medical Society's Committee on Health Economics of American Life (HEAL), addressed the Janesville Rotary Club July 9 and the Madison West Exchange Club July 12 on health care of the aged.

Dr. Olson Seeks Coroner's Post

Dr. Lyle Olson, Darlington, has announced that he will be a candidate for the office of coroner in Lafayette county. He will seek nomination on the Republican ticket in a three-way race in the September primary election.

Dr. Fox Locates at Germantown

Dr. Theodore C. Fox, who has been practicing at Minocqua for the past year, opened his offices at Germantown the middle of June. Doctor Fox previously had been a general medical officer for the U. S. Navy on the island of Formosa.

Dr. Emanuel Addresses Rotary

Dr. Dean A. Emanuel, member of the Marshfield Clinic staff, addressed the Marshfield Rotary Club in June on the subject of "Cholesterol and Its Relation to Heart Disease." He was introduced to the Rotarians by *Dr. Richard Rowe*, program chairman.

Lewis Brothers Provide Program

When Dr. Steven Lewis, professor of plastic surgery and assistant dean of the medical school at the University of Texas in Galveston, spoke before 40 physicians in the Marshfield Clinic library late in June, he was introduced by his brother, *Dr. Russell F. Lewis*, of the Clinic. The Texas physician, who has been doing clinical work and research work on burns, discussed their treatment, with special emphasis on skin grafting in severe burn cases.

Physicians whose names appear in italic are members of the State Medical Society.

Madison Doctors Active in ACOG

Dr. John R. Healy, *Dr. C. Weir Horswill*, *Dr. William Kiekhofer* and *Dr. Allen E. Schultz*, all of Madison, have been inducted as fellows into the American College of Obstetricians and Gynecologists. They are among 485 new fellows of the College of which *Dr. Ben M. Peckham* of the University of Wisconsin Medical School is Wisconsin chairman for 1963.

Dr. Zolot Opens Madison Office

Dr. Marvin M. Zolot, formerly chief medical resident at the University Hospitals, Madison, has opened an office for the practice of internal medicine in Madison. Doctor Zolot graduated from the University of Illinois College of Medicine, completed his internship at Philadelphia General Hospital, and served one year of residency at the University of Illinois Research Hospital in Chicago before coming to Madison. He served as chief of professional services at the U. S. Army Dispensary, Ft. Sheridan, Ill., from 1958 to 1960.

Dr. Sheehan Receives Promotion

Dr. Edward T. Sheehan, Milwaukee, has been promoted to professor of psychiatry in the Marquette University School of Medicine at Milwaukee.

Dr. Stuessy Stays on Health Council

Dr. M. W. Stuessy, Brodhead, has been reelected to the board of directors of the Wisconsin Health Council. Doctor Stuessy, a past president of the organization, serves as representative of the State Medical Society on the board of directors.

Dr. Damon Joins Waupun Clinic

Dr. Richard A. Damon, a native of Council Bluffs, Ia., joined the Waupun Clinic staff the end of June. A 1957 graduate of the University of Iowa Medical School, Doctor Damon served his internship in Ogden, Utah, served three years with the U. S. Army in Germany, and spent the past year with the Student Health Service at the University of Michigan in Ann Arbor.

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WISCONSIN PHYSICIANS *continued*

Health Council Hears Dr. Rusch

Guest speaker at the annual Polk County Public Health Council business-dinner meeting held at St. Croix Falls in June was *Dr. Kenneth H. Rusch*, director of the Community Mental Health Service, Division of Mental Hygiene, State Department of Public Welfare. His topic was "Community Mental Health Clinics."

Watertown Medical Center Open

Watertown's new medical center, which is known as Doctors' Court, opened early in June. Under the title of Medical Associates of Watertown, *Dr. E. Allen Miller*, *Dr. Eugene Schuh* and *Dr. Robert C. Baldwin* occupy one building. A second building houses *Dr. E. E. Burzynski*, eye, ear, nose and throat specialist.

Dr. Mannis Takes VA Post

Dr. Harry Mannis, Sparta, has accepted a position on the medical staff of a Veterans Administration hospital at Sepulveda, Calif., near Los Angeles. He will be chief of hospital staff personnel and chief of admissions. Doctor Mannis practiced medicine in Sparta for 24 years with the exception of 2 years when he served with the Navy on Guam and Okinawa in the Pacific.

Dr. Arthur J. Harris, Doctor Mannis' partner, will continue to practice in Sparta.

Dr. Nause Honored

Members of the Sheboygan Health Department recently honored *Dr. F. A. Nause*, part-time health commissioner of Sheboygan, who will retire August 31. Doctor Nause, a practicing physician in Sheboygan for more than 40 years, has been serving as acting public health commissioner since 1957. He served as city health officer in 1928, as city physician from 1930 to 1934, and as president of the Board of Health from 1928 to 1939.

Dr. Rupel Inducted as Fellow

Dr. John W. Rupel, of the Marshfield Clinic, is among the latest group of fellows inducted into the American College of Obstetricians and Gynecologists.

Honored for 50 Years in Practice

Fifty years ago, after his graduation from the Marquette University School of Medicine in 1912, *Dr. Franklin W. Lehmann* opened his office in Hartford and has continued to practice there since that date. Last spring he was honored at a dinner given by the sisters of St. Joseph's Hospital, and he also was admitted to the 50-year club of the State Medical Society at its annual meeting in May.

Hartford Times–Press Photo

Dr. F. W. Lehmann reflecting at his desk after 50 years of practice.

During the first week of the flu epidemic during World War I, Doctor Lehmann reminisces, he had two drivers and seven horses for the purpose of getting around to see his patients. He recalls the time when "confinement work was entirely a matter of home care and it required considerable educational talk on the part of the physician to have patients finally accept hospitalization except in desperate cases."

Two Join Osceola Clinic Staff

Dr. Paul Simenstad has resumed practice at the Osceola Clinic after having completed a three-year residency in internal medicine at the Veterans' Hospital and the University of Minnesota Hospitals, Minneapolis. Dr. Arthur Ludwig of Detroit, Mich., also has joined the Osceola Clinic staff. Doctor Ludwig received his medical degree from St. Louis University, and has completed two years of postgraduate study in medicine at the University of Minnesota.

Physicians Change at Rice Lake

Dr. John McKenzie and Dr. Donald Gallagher have left the Rice Lake Clinic to continue studies at the Milwaukee County hospital. Doctor McKenzie, who joined the clinic staff six years ago, will take postgraduate work in radiology. Doctor Gallagher, who has been with the clinic for the past two years, will study obstetrics and gynecology.

Dr. John Hoyer, a University of Wisconsin graduate who interned at St. Mary's Hospital in Duluth, Minn., and for the past year has been with the Duluth Clinic, is one of the replacements.

Dr. Krohn Cited for Service

Dr. Gene Krohn, who plans to resume his position on the staff of the Krohn Clinic at Black River Falls upon completion of his service requirements, has been awarded a citation and Com-

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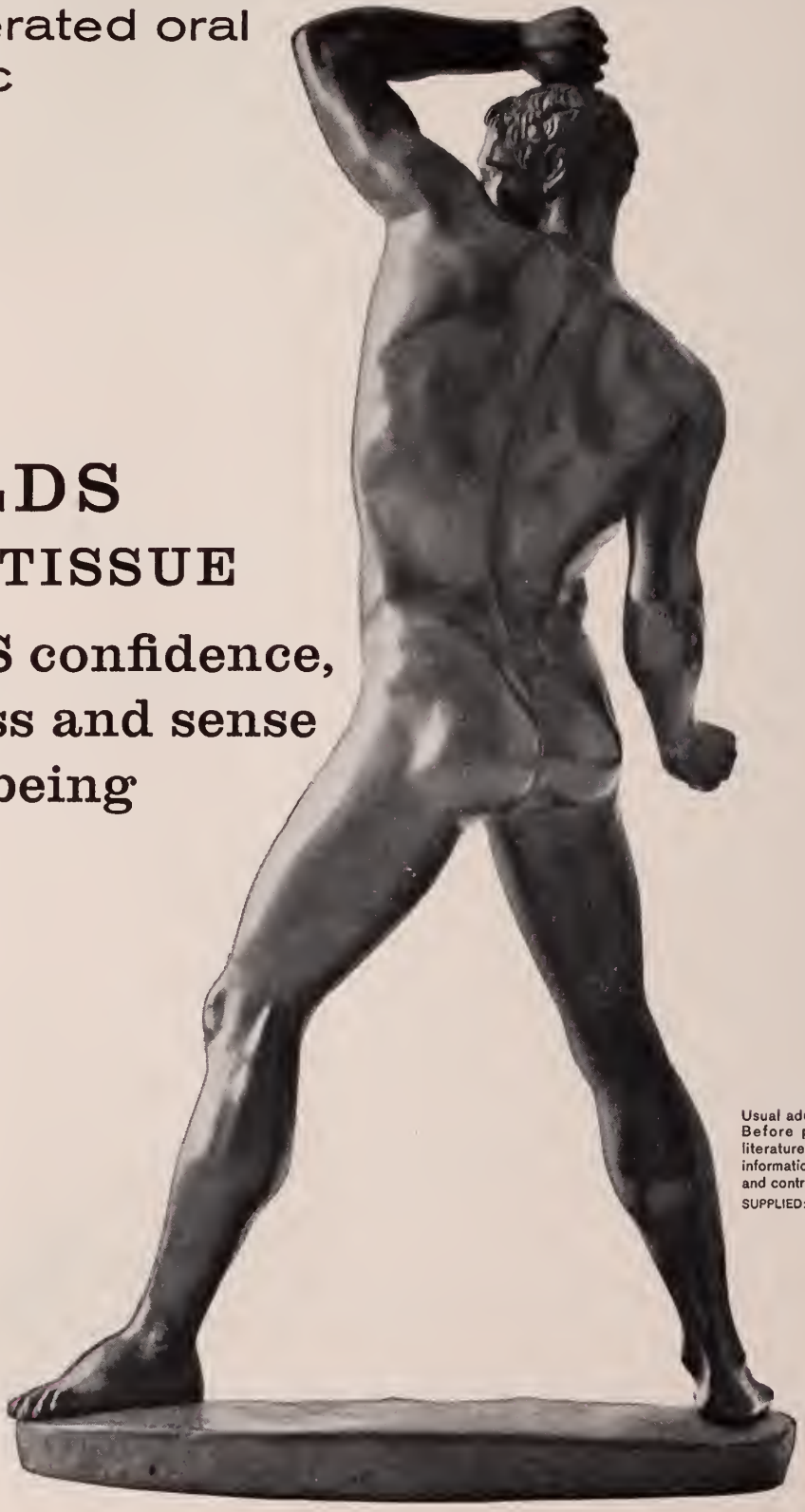

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mendation Medal for meritorious service. Stationed at the Peace, New Hampshire, Air Force Base since January of this year, Doctor Krohn was cited for meritorious service as a medical staff officer with the 6045th USAF Hospital in Korea from December 3, 1960, to December 15, 1961.

Dr. Newhouser Joins Madison Clinic

Dr. Charles Newhouser, Madison, entered general practice at the Madison East Clinic July 15 after completing his internship at Madison General Hospital. He attended the University of Wisconsin Medical School.

Wautoma Lions Club Honors Dr. Beck

The Lions Club of Wautoma has honored *Dr. A. A. Beck*, Wautoma physician for 55 years, with an honorary life membership in the organization. Doctor Beck, who tried to retire five years ago, continues to serve the townspeople when he is needed and frequently serves the needy without receiving pay. He also is county coroner.

Red Cedar Clinic Gets Member

Dr. Robert Q. Christensen joined the staff of the Red Cedar Clinic in Menomonie July 2. A native of Algoma, Doctor Christensen took his premedical and medical training at the University of Iowa and received his M. D. degree in June, 1958. After a one-year medical internship at the Sacred Heart General Hospital at Eugene, Ore., Doctor Christensen spent two years in the U. S. Air Force Medical Corps. In June of this year he completed one year in a pathology residency at the University of Iowa Medical School.

Dr. Tenney Addresses HEED Group

Dr. H. Kent Tenney, professor emeritus in pediatrics of the University of Wisconsin Medical School, spoke to the Help Educate Emotionally Disturbed Children (HEED) group June 27 at the Nichols school in Madison. His topic was "The Physician's Role in the Problems of the Emotionally Handicapped Child."

Dr. Herzberger Presents Paper

Dr. Eugene E. Herzberger of The Monore Clinic addressed the American Medical Association meeting in Chicago in June on "Anterior Cervical Fusion in the Treatment of Cervical Disc Disease." Dr. George W. Smith, professor of surgery and chief of neurosurgery at Medical College of Georgia, Atlanta, commented on Doctor Herzberger's improved methods in this line of surgery which he started in 1954 at Johns Hopkins University, Baltimore. Doctor Herzberger learned the technique while associated with Doctor Smith at Johns Hopkins and

The Monroe Evening Times Photo

Dr. Eugene E. Herzberger af Monroe and Dr. George W. Smith of Atlanta, Geargia

since coming to Monroe has applied it, with improvements, to 66 patients.

Dr. Bachhuber Honored by Community

In appreciation of 26 years of service to the Alma community, *Dr. Max O. Bachhuber* was honored by the Alma Booster Club at a testimonial dinner given at the Catholic church in Alma June 21. The event also marked the 30th anniversary of his receiving his degree of Doctor of Medicine from the University of Wisconsin.

Dr. Garner Addresses Seminar

Dr. Lawrence L. Garner, director of the Glaucoma Referral Center, Marquette University School of Medicine, and ophthalmologist, Veterans Administration Regional Office, addressed the Adult Vision Conservation Seminar held at Chicago June 5–6. The seminar was sponsored by the Neurological and Sensory Disease Service Program and the Regional Office of the U. S. Public Health Service. Subject of Doctor Garner's paper was "Physiology and Pathology of the Adult Eye."

Dr. Ostenso Joins Marshfield Clinic

The addition of Dr. R. S. Ostenso, a specialist in ear, nose and throat, brings to 41 the number of active physicians on the staff of the Marshfield Clinic. Doctor Ostenso received his medical degree from the University of Wisconsin Medical School in 1954 and interned at Gorgas Hospital in the Panama Canal Zone. He received his specialty training at the University of Pennsylvania Graduate School of Medicine and then practiced medicine at Gorgas Hospital in the Canal Zone.

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Surgery of Colon and Rectum, One Week, September 17

Surgery of Stomach and Duodenum, One Week, September 24

Vaginal Approach to Pelvic Surgery, One Week, Sept. 10

Gynecology, Office and Operative, Two Weeks, September 17

Obstetrics, General and Surgical, Two Weeks, October 8

Urology, Two Weeks, October 29

Proctoscopy and Sigmoidoscopy, One Week, September 10

General Practice Review, One Week, October 8

Gallbladder Surgery, 3 Days, October 8

Surgery of Hernia, 3 Days, October 11

Basic Electrocardiography, One Week, October 1

Board Review, Internal Medicine—Part I, September 10

Advances in Medicine, One Week, October 15

Advances in Surgery, One Week, December 10

Blood Vessel Surgery, One Week, October 22

Board of Surgery Review, Part I, Two Weeks, November 5

Board of Surgery Review, Part II, Two Weeks, November 26

Fractures and Traumatic Surgery, Two Weeks, October 1

Information concerning numerous other continuation courses available upon request.

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CALENDAR OF MEETINGS

Wisconsin

1962

Aug. 23–25: Postgraduate Course on Cancer Chemotherapy, University of Wisconsin Medical School, Madison.

Aug. 25: Eli Lilly Symposium, Wisconsin Academy of General Practice, Land O'Lakes.

Sept. 12–14: Aviation Medical Service Seminar, University of Wisconsin Medical School, Madison.

Sept. 14–16: Annual meeting of the Wisconsin Radiological Society, Maxwelton Braes Country Club, Bailey's Harbor.

Sept. 18–20: Wisconsin Academy of General Practice, Milwaukee.

Oct. 4: Postgraduate Course on Diagnostic and Therapy Problems Commonly Occurring in General Practice, University of Wisconsin Medical School, Madison.

Oct. 15–19: Postgraduate Course on Biologic Foundations for the Medicine of Tomorrow, American College of Physicians, University of Wisconsin, Madison.

Oct. 19–21: Postgraduate Course on Recent Concepts in Radiology Marquette University School of Medicine, Milwaukee.

Oct. 20: Cancer Scrimmage, UW, Madison.

Oct. 23–25: (Tentative) Conferences on "Strokes—What Can We Do About Them?" Sheboygan (23rd), Wausau (24th), Eau Claire (25th).

Oct. 26–27: Joint meeting, North Central Section of the College of American Pathologists and the Wisconsin Society of Pathologists, at Marquette U., Milwaukee.

Nov. 1: Postgraduate Course on Surgical Emergencies Confronting the General Practitioner, University of Wisconsin Medical School, Madison.

Nov. 14–15: Scientific meeting of The Medical Society of Milwaukee County, Milwaukee.

Dec. 12–13: Postgraduate Course on the Nonoperative Therapy of Malignancy, Marquette University School of Medicine, Milwaukee.

Out-of-State

Aug. 29: Medical Society Executives Association Institute, Drake Hotel, Chicago.

Aug. 30–31: AMA Institute, Drake Hotel, Chicago.

Sept. 9–13: International College of Surgeons 13th Biennial Congress, Waldorf–Astoria Hotel, New York.

Sept. 9–15: International Congress of Dermatology, Washington, D. C.

Sept. 17–20: American Hospital Association Annual Meeting, Chicago.

Sept. 19–20: Postgraduate course on Pediatrics, State University of Iowa College of Medicine, Iowa City, Ia.

Sept. 28–29: Postgraduate course on Urology, State University of Iowa College of Medicine, Iowa City, Ia.

Oct. 1–4: Scientific meeting of the Interstate Postgraduate Medical Assembly, Palmer House, Chicago.

Oct. 15–19: Clinical Congress of American College of Surgeons, Atlantic City, N. J.

Oct. 20–22: American Society of Anesthesiologists annual meeting, Statler Hilton Hotel, New York.

Oct. 26–28: Annual Scientific Sessions of American Heart Association, Public Auditorium, Cleveland, Ohio.

Nov. 1–2: American Rhinologic Society annual meeting, Statler Hilton Hotel, Los Angeles.

Nov. 1–3: Academy of Psychosomatic Medicine annual meeting, Radisson Hotel, Minneapolis, Minn.

Nov. 1–3: Annual Course in Postgraduate Gastroenterology of the American College of Gastroenterology, Morrison Hotel, Chicago.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California

Medical Meetings

Postgraduate Courses

Eighth Annual Fall Cancer Scrimmage

Inquiries on the Eighth Annual Fall Cancer Scrimmage to be held at the University of Wisconsin Medical Center October 20, beginning at 9 a. m., may be mailed to Box 1626, Madison 1. No fee is asked. Luncheon tickets are at cost, as are football tickets.

Academy of Psychosomatic Medicine

The Academy of Psychosomatic Medicine will hold its annual meeting November 1–3 at the Radisson Hotel in Minneapolis, Minn. The meeting is open to all physicians.

International College of Surgeons

The International College of Surgeons will hold its 13th Biennial Congress at the Waldorf-Astoria Hotel, New York, September 9–13. A. Mario Dogliotti, M. D., Torino, Italy, president of the College, will preside.

Max Simon, M. D., Poughkeepsie, N. Y., is chairman of the program which will be divided into two main areas: 1) general assembly program, and 2) specialty group programs. In addition, two special features will be a program for surgical nurses and the first annual junior candidate surgical seminar. More than 200 papers and panel discussions will be presented by essayists from 27 different countries.

Medical Editors Conference

"Communications in Asian Medicine" will be the theme of the 13th Medical Editors Conference which will be held in conjunction with the 16th General Assembly of The World Medical Association in New Delhi, India, November 11–16. The Medical Editors Conference, to be held on November 13, will be presided over by Dr. P. K. Guha, past editor of the Journal of the Indian Medical Association.

American College of Physicians

The first American College of Physicians Sectional Meeting, featuring three days of clinical sessions and combined basis science and clinical investigation sessions, will be held in Detroit, Mich., November 21–23, 1963. It will augment the College's 44th Annual Session, scheduled for April 1–5, 1963, in Denver, Colo.

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Sa far, so goad. But what should we do now?

. . . The health insurance business needs ta be identified with an interest in the heolth ond medical care of our peaple as distinguished from a dedication ta spreading cost at a profit.

. . . One way to do this is to promote the development af needed health and medical care facilities.

. . . At aur May meeting, Doctor Blasingame of the American Medical Associatian told us that better nursing hame focilities far long-term care of the aged, especially those over the age of 75, canstitute the most urgent health care need befare the nation today. This should be af deep concern to the health insurance business. Of the 14,000 nursing homes in the country fewer than 40% are members of prafessianal nursing hame assaciations. Mast are privately owned and 50% of the patients are being paid for with public funds. The average skilled nursing hame has 25 beds and the cost per patient is about $6 to $8 per day. The average of peaple in nursing homes is 80, and 90% are aver age 65. The relatianship of this facility far care to the problems of older people is readily discernible.

Here is an area where dactars, hospitals and health insurers should wark together with the praper kind af representatian of the nursing home business. It is necessary to develop standards for qualification, operation and use. The determination of need by location must be made. Under some conditions we could be helpful in praviding nursing hame care in conjunction with o hospital, possibly with the help of federal funds.

. . . Much can be dane ta encourage provisian for rehabilitatian facilities.

. . . Accident preventian also ties in with the reductian of losses under health insurance policies. Casuolty insurers which underwrite liability for injuries under workmen's compensation laws and the comman law spend considerable sums of money in studying and advancing safety. . . . The health insurance business might well identify itself with these efforts which have impressed gavernment and citizens alike.

A look ahead for a business which has matured as fast os the health insurance business brings into focus needs for intelligent action of o kind not dreamed of ten years oga. The image of health insurers to be held by the American peaple will become increasingly important. Business growth is necessary, but growth alone is not enough. Our companies must be regarded not only as mechanisms ta spread the cast of medical care but also as mativators of improvement in health. Our business must wear a mantle of humanity. This is the kind af a business which the Americon people will not want to extinguish in favor of government monopoly.

Excerpts from an address given by the President of the Health Insurance Assaciation af America, Millard Bartels, befare the HIAA Individual Insurance Farum, Chicaga, October 24, 1960.

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MEDICAL MEETINGS *continued*

Iowa Postgraduate Courses

Conferences in pediatrics and urology will open the 1962–1963 series of 18 medical postgraduate conferences at the State University of Iowa College of Medicine. A pediatrics conference on September 19–20 will focus on malignant disease in children; the problems of mental retardation; chronic disease and ulcerative colitis. The urology conference on September 28–29 will deal with problems of pediatric urology. Write John A. Gius, M.D., Director of Postgraduate Medical Studies, Office of the Dean, College of Medicine, Iowa City, Ia., for details.

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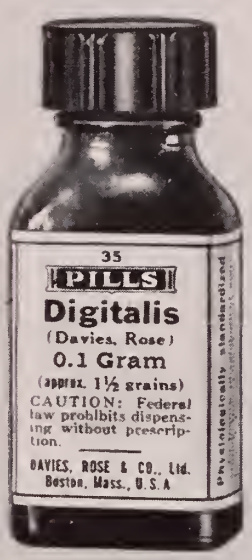

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MEDICAL MEETINGS *continued*

American Society of Anesthesiologists

The annual meeting of the American Society of Anesthesiologists will be held at the Statler Hilton Hotel in New York City October 20–26. Refresher courses, which will include 106 lecturers giving 131 different topics, are scheduled for October 20–22. Reservations for the courses should be made at the earliest possible date.

American Rhinologic Society

An introductory course in "Expanded Surgery of the Nasal Septum and Closely Related Structures" will be presented at the Loma Linda University School of Medicine, Los Angeles, October 29 to November 1. Among the lecturers will be Dr. Erwin E. Gaynon, Milwaukee.

The American Rhinologic Society will hold its eighth annual meeting in the Statler Hilton Hotel, Los Angeles, November 1–2. The main scientific program will be presented on November 2.

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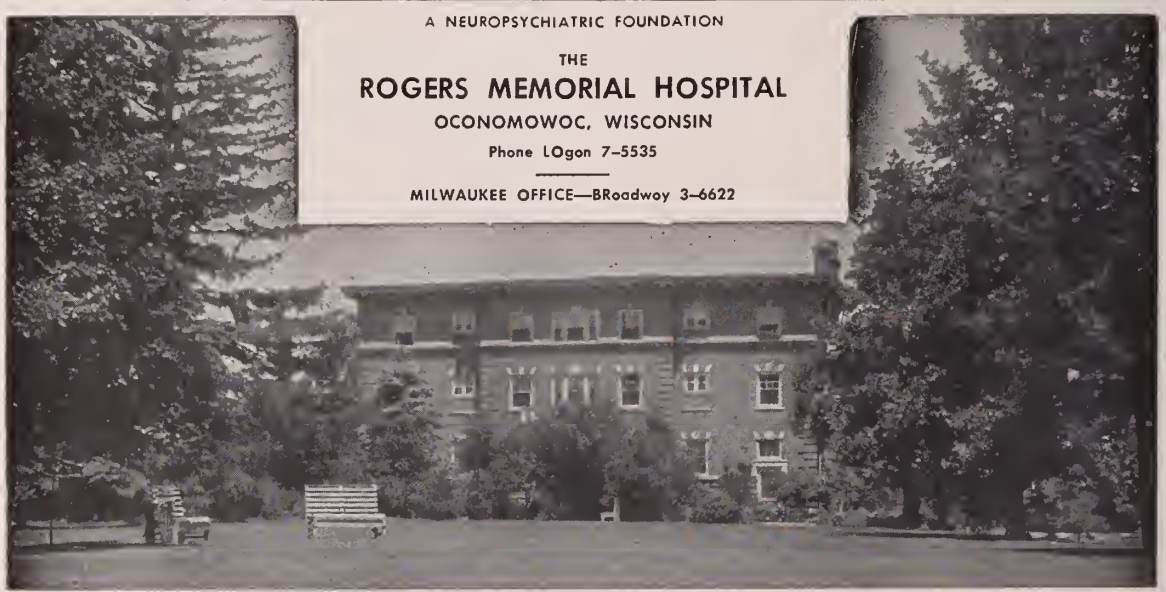

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MEDICAL MEETINGS *continued*

Wisconsin Society of Internal Medicine

The 1962 annual meeting and scientific program of the Wisconsin Society of Internal Medicine will be held at Eau Claire September 14 and 15. After welcoming remarks by Dr. Leslie G. Kindschi, Monroe, president of the Society, the morning session on Friday, September 14, will be devoted to "Current Problems of Endocrinology and Pathologic Physiology." Speakers and their subjects will include Dr. Edwin Albright, professor of medicine, University Hospitals, Madison, "The Problem of Nodular Goiter;" Dr. Leslie Zieve, director Radioisotope Service, Veterans Administration Hospital, Minneapolis, Minn., "Some Studies of Pancreatic Enzymes;" Dr. Alfred Eichenholz, Veterans Administration Hospital, Minneapolis, Minn., "Compensatory Mechanisms in Acid Base Balance;" Doctors Albright, Zieve and Eichenholz, "Endocrinology," a panel discussion.

Dr. Warren K. Simmons, Rhinelander, president-elect of WSIM, will preside at the Friday afternoon session. Dr. Jerome Conn, professor of medicine, University of Michigan Medical Center, Ann Arbor, will deliver the William S. Middleton lecture on "Primary Aldosteronism." Dr. Jesse Edwards, director of laboratories, Charles T. Miller Hospital, St. Paul, Minn., will present a paper on "A Pathology of Mitral Insufficiency."

Newly elected officers of the Society will be installed at a banquet at the Eau Claire Country Club Friday evening. August Derleth, Wisconsin author, will speak about "An Author's Relation with the Characters of His Home Milieu."

A postgraduate program on "Cardiovascular Disease" is scheduled for Saturday, September 15. Dr. George E. Gutmann, Janesville, will preside at the morning session which will include W. B. Youmans, professor of physiology, University of Wisconsin Medical School, Madison, "Mechanisms of Production of Elevated Venous Pressure;" Doctor Edwards, "Diseases of the Thoracic Aorta;" and Dr. Howard T. Burchell, professor of medicine, Mayo Clinic, Rochester, Minn., "Peripheral Auscultation—Dividends." There also will be a panel discussion on "Heart Failure."

Dr. John H. Wishart, Eau Claire, will preside at the Saturday afternoon sessions. The program will include Dr. Charles W. Crumpton, professor of medicine, University Hospitals, Madison, "Pharmacodynamics of Coronary Vasodilators;" Dr. John Huston, associate professor of medicine, Marquette University, Milwaukee, "Pharmacology in Cardiac Resuscitation;" and a panel discussion on "Pharmacologic Aspects of Cardiovascular Disease."

Wisconsin Society of Pathologists

On October 26 and 27 there will be a joint meeting of the North Central Section of the College of American Pathologists and the Wisconsin Society of Pathologists at the Marquette University School of Medicine, Milwaukee. The two-day session will consist of a scientific program followed by a seminar on soft tissue tumors.

Dr. David Carlson, Milwaukee, president of the Society, will preside. The morning session on Friday, October 26, will include: "Evaluation of New Clot Timer in Coagulation Studies," by Dr. David La Fond, Milwaukee; "The Broad Significance of the Coagulation Reaction," by Dr. Armand J. Quick, Milwaukee; "Erythrocyte Glucose -6- Phosphate Deficiency," by Dr. S. R. McCreadie, Milwaukee, and "Studies on Agranulocytosis," by Dr. Anthony V. Pisciotta, Milwaukee.

Topics scheduled for the Friday afternoon session are: "Lymphocytogenesis," by Dr. R. Dorothy Sundberg, Minneapolis; "Bone Marrow Biopsy in Lymphatic Malignancies," by Dr. Joseph M. Lubitz, Milwaukee; "Cytology of the Immature Lymphocytic Malignancies," by Dr. John W. Rebuck, Detroit; "Current Legislation Affecting the Practice of Pathology," by Dr. Oscar B. Hunter, Jr., Washington, D.C., and "College of American Pathologists," by Dr. Arthur H. Dearing, Chicago.

The annual dinner and business meeting will be held Friday evening at the Coach House Motor Inn.

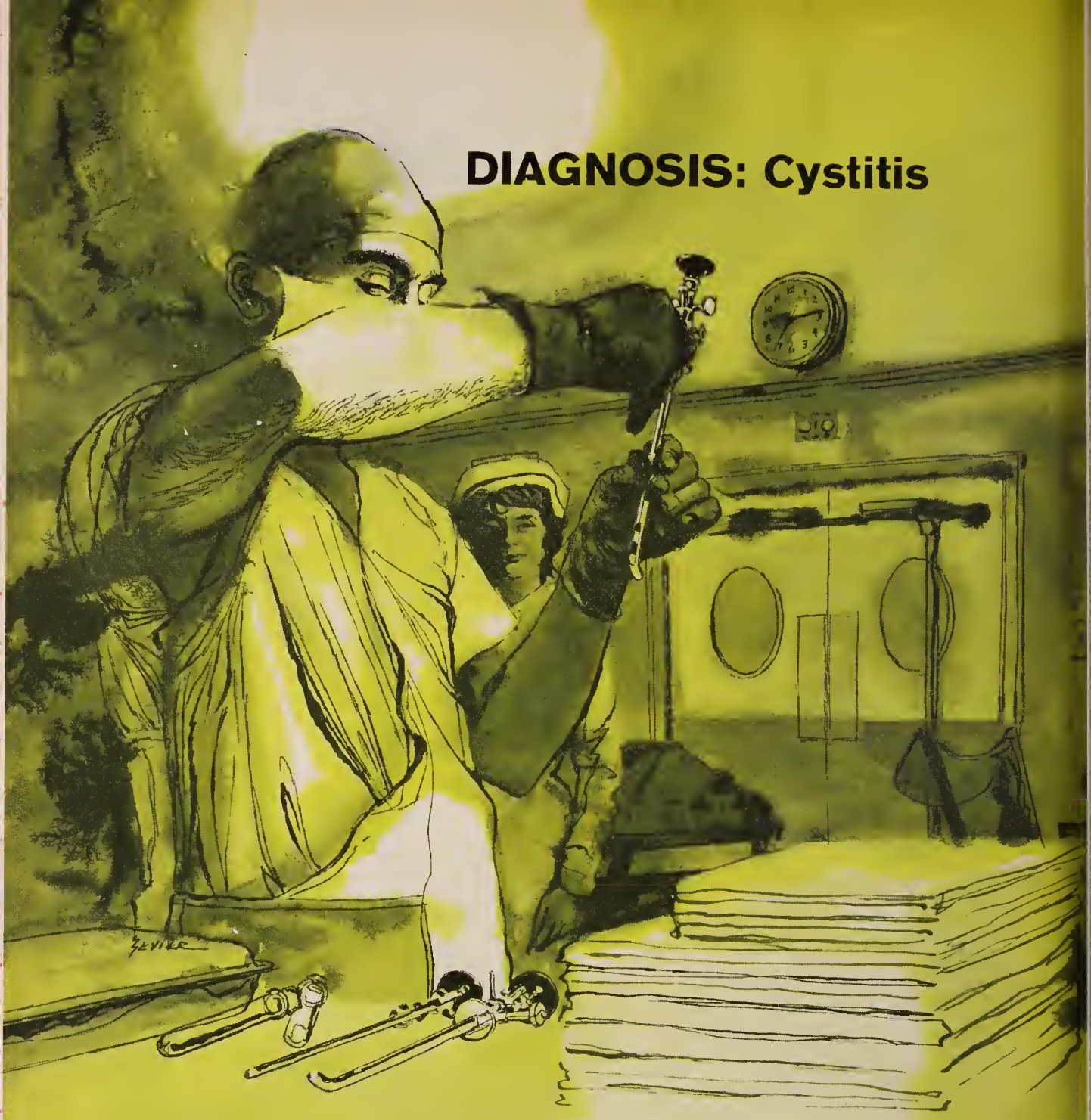
The morning session on Saturday, October 27, will continue the scientific program with "Axostasis, A Pathological Lesion Induced by Chemical Means," by Dr. H. A. Hartmann and S. M. Chou, Madison; "Pathologic Effects of Experimental Hypoxia," by Dr. Enrique Valdivia, Madison; "Medicolegal Aspects of Cerebral Vascular Occlusion," by Dr. L. J. Van Hecke, Milwaukee; "The Cytogenetics of Congenital Anomalies and Fetal Loss," by Dr. S. L. Inhorn, Madison, and "Recent Studies on Pyelonephritis," by Dr. Paul Kimmelstiel, Milwaukee.

Dr. Rafael Lattes, New York, will moderate a seminar on soft tissue tumors during the Saturday afternoon session.

Inquiries for reservations and further information should be directed to: Robert S. Haukohl, M.D., Secretary, Wisconsin Society of Pathologists, 561 North 15th Street, Milwaukee 3, Wisconsin.

American Medical Writers Association

"The Information Explosion—Its Challenge and Problems" will be the theme of the 19th annual meeting of the American Medical Writers Association at the Sheraton Park Hotel in Washington, D.C., October 12–13. What can be done to meet the challenge of the flood of new medical information, advances in information storage and retrieval, utilization of the newer communication media, and professionalism among medical communication personnel will be discussed.



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Society Records

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D. K. Shakrokh, 31 North Sallie Avenue, Fond du Lac.
David F. Miller, 611 South Farwell, Eau Claire.
Donald W. Schulz, 139½ South Main Street, Shawano.
Joseph P. Looze, V. A. Center, Wood.
Alfons Busza, 750 North 18th Street, Milwaukee.
Richard L. Fodor, 8700 West Wisconsin Avenue, Milwaukee.
Jerome V. Blum, 425 East Wisconsin Avenue, Milwaukee.
Thomas E. Simonsen, 3001 South 56th Street, Milwaukee.
James P. Connaughton, 1220 Dewey Avenue, Milwaukee.

CHANGES OF ADDRESS

E. F. Carl, to 2500 North 108th Street, Milwaukee.
J. W. Schaller, to 184 Second Street, North, Wisconsin Rapids.
E. E. Burzynski, to 1518 Doctor's Court, Watertown.
Mary C. Berg, to 4801 Holiday Drive, Madison.
James B. Shack, to 710 Main Street, Racine.
Stanley Grosshandler, Glendale, to 8700 West Wisconsin Avenue, Milwaukee.
Robert F. Lipo, Tumwater, Washington, to 2010 South 107th Street, Milwaukee.
Loren J. Yount, Milwaukee, to 14307 West Gatewood, New Berlin.
Don H. Martin, Fox Point, to General Delivery, Arcadia.
*Capt. Roland C. Brown, San Antonio, Texas, to 3973 USAF Hospital (SAC) Box 6556, APO 282, New York, N. Y.
Julian S. Sachs, New York, to Box 275, Melbourne Beach, Florida.
J. P. Hartwick, New Berlin, to Route 4, Box 759, Fayetteville, North Carolina.
Robert S. Bujard, Madison, to Winnebago State Hospital, Winnebago.
W. W. Stebbins, St. Petersburg, Florida, to 2121 West Lawn Avenue, Madison.
O. M. Larimore, Waupun, to R. F. D. #1, Pelican Point, Detroit Lakes, Minnesota.
Henry C. La Brec, Milwaukee, to 2210 South 23rd Street, La Crosse.
Sigwert W. Simonson, La Crosse, to Route 1, Prairie Lake, Chetek.
M. F. Lindquist, Eau Claire, to 724 19th Avenue, North, South St. Paul, Minnesota.

*Military member.

Membership Report as of June 30, 1962

NEW MEMBERS

Martin Z. Fruchtman, 324 West Main Street, Waukesha
Thomas D. Ghrist, 30 South Henry Street, Madison 3.
Edgar A. Hawk, 621 South Park Street, Madison.
Charles Nemeth, P. O. Box 607, Fond du Lac.
Marilyn J. O'Brien, 1836 South Avenue, La Crosse.
Robert J. Rasmussen, 217 Wisconsin Avenue, Waukesha.
Stanley F. Vognar, 103 Main Street, Mt. Horeb.
Marvin M. Zolot, 1901 Monroe Street, Madison.

CHANGES OF ADDRESS

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John P. Docktor, to 161 West Wisconsin Avenue, Milwaukee 3.
John C. Ellis, Jr., to 2 West Gorham Street, Madison 3.
T. J. Foley, to 540 Honey Creek, Milwaukee 13.
O. M. Hitch, to 535 South Monroe, Green Bay.
Louis Kagen, to 949 North 12th Street, Milwaukee 3.
Joyce C. Kline, to 10 D University Houses, Madison.
Frank Larson, to University Hospitals, Madison 6.
Jack D. McKenty, to 2040 West Wisconsin Avenue, Milwaukee 3.
Flavio Puletti, to 10 D University Houses, Madison.
J. R. Stone, to 949 North 12th Street, Milwaukee 3.
Robert S. Wright, to 3900 Erie Street, Racine.
Victoriano A. Baylon, Milwaukee, to Clinical Laboratory, Mercy Hospital, Janesville.
Glen G. Cramer, Osceola, to 2551 McKinley Street, NE, Minneapolis 18, Minnesota.
E. C. Eickhoff, Land O'Lakes, to 409 West Main Street, Bozeman, Montana.
J. J. Ferrari, Green Bay, to % Fetzer, 323 Beach, 92nd Street, Rockway Beach, Long Island, New York.
A. Yale Gerol, Racine, to 6530 Sheridan Road, Kenosha.
D. M. Green, Wausau, to 16 North Gate Broadmoor, Colorado Springs, Colorado.
D. H. Hinke, Richland Center, to 2906 Grandview Boulevard, Madison 13.
Don H. Martin, Arcadia, to 9640 North Regent Court, Fox Point 17.
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Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

BOOK REVIEWS

PEDIATRIC SURGERY

Edited by Doctors Benson, Ravitch, Mustard, Snyder and Welch, Yearbook Medical Publishers, Chicago, Ill., 1962.

A two volume reference on pediatric surgery has just been published by Yearbook Medical Publishers. It is edited by five surgeons, Benson, Ravitch, Mustard, Snyder, and Welch. There are 79 contributors. As stated in the preface, each contributor expresses his own feelings on controversial points and evaluates the work of others. There is a good bibliography after each presentation. Illustrations and photographs are quite good. Since most of pediatric surgery encompasses the abdomen, thorax and genitourinary system, the greater part of the books is devoted to those problems. There also are chapters on orthopedics and neurosurgery. These two volumes will be a valuable reference for the house staff and all general surgeons. They are a comprehensive presentation of practically all of the surgical problems the physician might encounter in infants and children.—SHIMPEI SAKAGUCHI, M.D., Milwaukee

(Editor's note: The above review was submitted voluntarily and is not a part of the reviews submitted by the University of Wisconsin faculty.)

BLOOD DISEASES OF INFANCY AND CHILDHOOD

By Carl H. Smith, M.D., Professor of Clinical Pediatrics, Cornell University Medical College, New York, N.Y. C. V. Mosby Co., St. Louis, Mo., 1960. 572 pages. Price: $17.00.

This work, the first to appear in this area in many years by a recognized authority in the field, has been received with enthusiasm by pediatricians and pediatric hematologists. Although not definitive in scope, its concise presentation provides abundant basic information regarding essentially all aspects of the field of clinical hematology as pertains to the pediatric age group. The book is written with clarity and thoroughness suitable for a clinical treatise such as this is intended to be. It is regrettable that a paucity of illustrations is to be found in the book; however, those present are well reproduced and add greatly to the clarity of the presentation.

Of particular interest are the contributions on erythroblastosis fetalis, the general introductory chapters on the use of blood transfusions, and the general clinical approach to the diagnosis of the various hematological disorders.

Doctor Smith writes with broad experience and expert knowledge particularly in the areas of hemolytic anemias. A clinically useful treatment of blood coagulation and its disorders will be sincerely appreciated by many clinicians who find this rapidly growing area one almost too challenging in its confusing terminology. From the morass of new information, Doctor Smith has presented a concise and most useful discussion of the problems faced by the pediatrician in childhood hemorrhagic disorders.

I heartily recommend this book to all physicians seeing children as a concise and abundantly useful orienting text in the field of blood diseases in pediatric patients.—NATHAN J. SMITH, M.D.

MEDICAL, SURGICAL AND GYNECOLOGICAL COMPLICATIONS OF PREGNANCY

By the Staff of the Mount Sinai Hospital, New York City. Edited by Alan F. Guttmacher, M.D. and Joseph J. Rovinsky, M.D. The Williams & Wilkins Company, Baltimore. 1960. 619 pages. Price: $16.50.

The authors of this book are to be congratulated for their efforts in formulating a review of conditions associated with or complicating pregnancy. There are several sections especially to be recommended. Two of the best are sections discussing the cardiovascular-renal system and the section about erythroblastosis and maternal iso immunization.

The section on carcinoma in situ is controversial and I believe open to criticism. The author advises us to wait until the conclusion of pregnancy before making a final diagnosis of carcinoma in situ. This conclusion is based on the inability in 20 per cent of cases with definite diagnosis of carcinoma in situ made during pregnancy to establish definite proof of persistence of the condition following pregnancy. That the entire lesion may have been removed by the initial biopsies is of course a distinct possibility.

The author advocates making a definite diagnosis of invasive carcinoma, but appears doubtful about recommending cervical conization. The diagnosis of invasive carcinoma can be established or eliminated only by cervical conization in those patients showing carcinoma in situ on punch biopsies. In view of the poor prognosis for patients delivering through a carcinomatous cervix, the sequence of smear, punch biopsy, cone biopsy must be carried out where obvious invasive carcinoma is not seen on punch

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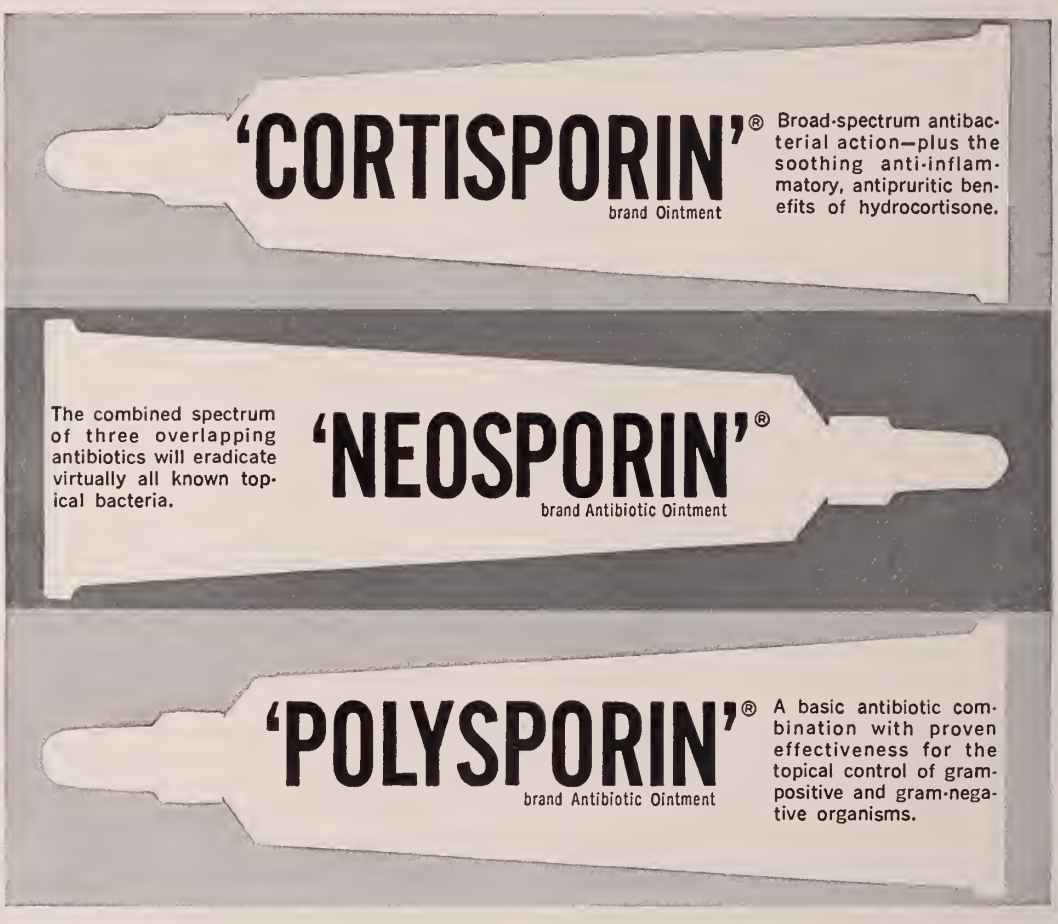

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biopsy, and the smear test suggests malignant cells or carcinoma in situ is found on punch biopsy.

This book is recommended to both generalist and specialist as an enlightening review. The brevity of material in many sections does not qualify this book as a complete reference book—JOHN C. ELLIS, JR., M.D.

VIRUS VIRULENCE AND PATHOGENICITY

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. and Cecilia M. O'Connor, B.Sc. Little, Brown and Company, Boston. 1960. 114 pages.

This small book contains the six papers and the discussion that made up the proceedings of a conference held in London in June, 1959. The conference was in honor of Dr. J. Mulder of the Netherlands to whom the subject has been of particular interest. Only 17 persons participated in the meeting, but in addition to J. Mulder the group included F. M. Burnet, C. H. Andrewes, C. H. Stuart-Harris, Wilson Smith and others well qualified to discuss virus virulence and pathogenicity authoritatively.

Papers on the definition and measurement of virus virulence, the role of host-cell factors, effect on virulence of changes in parasite and host, broad aspects of the virulence of influenza virus, the severity of influenza as a reciprocal of host susceptibility, and the virulence for man of some respiratory viruses passed in tissue culture provide the basis for extensive discussion of virus infection and host response to infection. Much of the content of the volume is concerned with the puzzling changes in severity seen in the recorded epidemics of influenza, but there is also interesting information on poliovirus, ECHO viruses, Coxsackie viruses, and various respiratory viruses.

Virulence and pathogenicity of virus infections is a subject that is rather difficult to pin down, but this book should be useful to persons interested in those aspects of infectious disease related to epidemiology, host reactions, and factors affecting host resistance.

—DUARD L. WALKER, M.D.

HANDBOOK OF POISONING

Diagnosis and Treatment. Second Edition. By Robert H. Dreisbach, M.D., Ph.D., Professor of Pharmacology, Stanford, California. Lange Medical Publishers, Los Altos, California. 1959. 474 pages. Price: $3.50.

Each day more and more poisonous agents are introduced commercially in a countless number of drugs and household and other preparations. Not only has the risk of being poisoned increased tremendously but it also has become impossible for almost any physician to know the chemical ingredients of these products and their toxicity. Further-

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more, plant and animal hazards are an ever present danger now that camping out has become such a popular form of recreation.

It is obvious then that physicians, and especially general practitioners and pediatricians, require a better knowledge of poisoning, its diagnosis and treatment. Such knowledge is available in the handbook discussed here. It is of course impossible to include and discuss all the possible poisons in such a compact booklet. However, during the four months that I was is charge of the Poison Control Center for the State of Wisconsin, I found this book of exceptional value and on almost every occasion I found in it the necessary information. The index is clear and includes the trade names of many dangerous commercial products not mentioned in the text. In these cases, reference is given by name to the one or two most toxic ingredients which such products contain.

Brevity and clarity are the main characteristics of this book and are of cardinal importance when time is pressing as is often the case with poisoning. I am sure that having this little handbook on hand will save many a long distance call and waste of important time for the physician.

However, since new poisons are being introduced into the market at a bewildering speed, I would prefer that this book be edited as a loose leaf notebook, so that once or twice yearly new information could be inserted in order to keep it up to date.

In short then, it is my opinion that this *Handbook of Poisoning* by Robert H. Dreisbach is a very valuable one for any physician in practice today and I therefore recommend it most highly.—LUC. LEMLI, M.D.

DO YOU KNOW?

In 1946, the average cost per patient day for general hospitals in this country was a little under $10 a day while now it is about $32 a day.—YOUR HEALTH, Pennsylvania Medical Society, Dec. 13, 1961.

W. B. SAUNDERS COMPANY

features the following recent books in their full page advertisement appearing elsewhere in this issue:

KLINE AND LEHMANN—HANDBOOK OF PSYCHIATRIC TREATMENT IN MEDICAL PRACTICE—Tells the nonspeciolist which psychiotric potients he should ond should not treot—why he should treat them—ond exoctly how to monoge these potients.

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Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 61, No. 9—SEPTEMBER 1962

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Specialty Society Proceedings

Wisconsin Heart Association

Dr. W. B. Hildebrand, Menasha, was named chairman of the 1963 Heart Fund campaign at a meeting of the board of directors of the Wisconsin Heart Association in July at the home of its president, *Dr. Raymond Rice,* Milwaukee. Two other physicians were among those named as chairmen of divisions. *Dr. John Huston,* Milwaukee, heads the physician education division and Dr. Hugh J. McLane, Fond du Lac, heads the community service and education division.

Drs. George G. Rowe, Madison, and *Donald M. Willson,* Milwaukee, are directors.

Doctor McLane's division will be composed of farmers, veterinarians, agricultural scientists and other researchers who will study research and find ways to improve dairy products. It will also coordinate facts on the growing issue of fats in the diet and arteriosclerotic heart disease.

Rock County Unit

The first regular meeting of the Rock County unit of the Wisconsin Heart Association was held in Janesville September 12. An organizational meeting with *Dr. Marshall F. Purdy,* Janesville, and *Dr. Robert Chancey,* Beloit, as co-chairmen, was held in Beloit August 1.

Purpose of the Rock county unit is to stimulate public and professional educational programs relating to cardiovascular diseases. A speakers bureau will be established in the Janesville-Beloit area. The bureau will furnish speakers, movies and literature to any organization or club in the area free of charge.

The unit plans to instruct medical and paramedical groups in the proper method of external cardiac massage.

Physicians whose names appear in italic are members of the State Medical Society.

Wisconsin Society of Obstetrics and Gynecology

Elected officers for the 1962–63 year have been announced by the Wisconsin Society of Obstetrics and Gynecology as follows:

President: *Dr. B. M. Peckham,* Madison
Vice-president: *Dr. Carlton Wirthwein,* Milwaukee
Secretary-treasurer: *Dr. Raymond E. Whitsitt,* Madison
Board of Governors: *Dr. Ralph E. Campbell,* Madison

Wisconsin Society of Public Health Physicians

At its annual meeting in May, the Wisconsin Society of Public Health Physicians elected the following officers for 1962–1963:

President: *Dr. J. A. Van Susteren,* La Crosse
President-elect: *Dr. E. R. Krumbiegel,* Milwaukee
Secretery-treasurer: *Dr. G. M. Shinners,* Green Bay
Delegate to State Medical Society: Doctor Shinners
Alternate: *Dr. E. E. Bertolaet,* West Allis
Delegate to A.A.P.H.P.: Doctor Krumbiegel
Alternate: *Dr. C. K. Kincaid,* Madison

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1 Ford, R. A., and Blanchard, K. Journal-Lancet 78:185, 1958

Formula: In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium para-amino-benzoate 0.3 Gm., ascorbic acid 50.0 mg.

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News of Wisconsin Physicians

Explains Care of Accident Victims

Dr. H. W. Carey, Lancaster, advised members of the Grant County Law Enforcement Association and visiting members of rescue squads from throughout the county on the proper methods of handling accident victims with various types of injuries. He spoke at the July meeting held at the Lancaster fairgrounds.

Dr. Davis Gives Equipment

Dr. R. R. Davis, New Richmond, has given a new diathermy machine to the physical therapy department of the Holy Family hospital in New Richmond. Doctor Davis' gift enabled the hospital to trade in its old diathermy machine on a muscle stimulator.

Dr. Walton Opens Madison Office

Dr. Judith D. Walton, who has been on the staff of the University of Wisconsin Medical School in the department of psychiatry, opened her office in Madison for the practice of psychiatry August 1. Doctor Walton was graduated from the University of Wisconsin Medical School in 1947 and interned at the University of Nebraska Hospital, Omaha. She was in general practice in New Mexico in 1948–1949, psychiatric resident at University Hospitals in Madison from 1950 to 1953, psychiatrist at Winnebago State Hospital in 1953–1954, and on the University psychiatry staff since 1954. She is a consultant to the State Department of Public Welfare's Division of Corrections and the County Mental Hospital system.

Donald F. Schwab, M.D.

Judith D. Walton, M.D.

Dr. Schwab Joins Dr. Moore

Dr. Donald F. Schwab has become associated with *Dr. J. N. Moore* in the general practice of medicine in Madison. A graduate of the University of Wisconsin Medical School, Doctor Schwab served his internship at Madison General Hospital. He served four years in the Navy during the Korean war.

Physicians whose names appear in italic are members of the State Medical Society.

Dr. Galasinski Debates Medical Care

Dr. Roman E. Galasinski, president of The Medical Society of Milwaukee County, expressed opposition to Federal aid for the aged ill at a meeting of the West Allis Woman's Club July 26.

Dr. Templeton to Be on Medford Staff

Dr. Howard Templeton, anesthesiologist who is on the staff of St. Mary's Hospital at Wausau, will be available for biweekly scheduled surgery at Medford as well as for emergencies.

Backs County Health Department Idea

Dr. G. M. Shinners, Green Bay, sixth distirct health officer, spoke on county health departments at a joint meeting of the League of Women Voters Health Study Committee and the United Community Services Public Health Service Committee of Appleton July 23. Doctor Shinners recommended one board of health and one health officer for Outagamie County in preference to the 31 boards and health officers now in existence.

Dr. Wong Conducts Civil Defense Sessions

Dr. James R. Wong, Crawford County Medical Director for Civil Defense, conducted two orientation sessions in Prairie du Chien July 25 and 26. The sessions were part of the Civil Defense Health-Medical Service program being carried out by the State Board of Health in cooperation with local civil defense authorities and medical personnel to acquaint medical groups with the operation of the emergency hospital.

VA Appointment for Dr. Musser

Dr. Marc J. Musser, a member of the University of Wisconsin Medical School faculty from 1938 until 1957, has been appointed the Veterans Administration's assistant chief medical director for research and education. Director of the VA medical research service since October, 1959, Doctor Musser now has additional responsibility for the medical education and training programs conducted by VA hospitals and clinics in affiliation with 76 medical schools, 33 schools of dentistry, and 113 schools of nursing. From 1941 to 1945, Doctor Musser served in the Army with the rank of colonel as commanding officer of the 135th Medical Group.

WISCONSIN PHYSICIANS *continued*

Dr. Olson Joins Madison Office

Dr. Ronald W. Olson has become associated with *Drs. George C. Hank* and *John R. Healy* in the practice of gynecology and obstetrics in Madison. A graduate of the University of Wisconsin Medical School, Doctor Olson interned at Madison General Hospital and had his specialty training at University Hospitals. He served with the Marine Corps from 1951 to 1953. He is a clinical instructor in the department of gynecology and obstetrics at the University of Wisconsin Medical School, and is on the staff of St. Mary's Hospital, Madison General Hospital and University Hospitals in Madison.

Ronald W. Olson, M.D.

P. J. Dougherty, M.D.

Menomonee Falls Group Adds Dr. Dougherty

Dr. Philip J. Dougherty recently has joined *Dr. Jack Hoffman* and *Dr. Richard Bibler* in the new Menomonee Falls clinic known as Medical Associates. Doctor Dougherty received his M.D. degree from the University of Illinois College of Medicine in Chicago in 1956 and interned at St. Francis Hospital in Peoria, Ill. He served as a Marine Corps physician in the U.S. Navy from 1957 to 1959. Marquette University School of Medicine recently appointed Doctor Dougherty an instructor in medicine, and he serves on the staff of Milwaukee County General hospital, Waukesha Memorial hospital and West Allis Community hospital.

Rib Lake Doctors Announce Plans

Dr. Robert L. Pettera, former Rib Lake physician, plans to extend his term of active duty with the National Guard an additional year to fulfill his military obligation. He has been transferred from the 32nd Division into the 4th Division, also stationed at Fort Lewis, Wash.

Dr. S. F. Hesse, who came from Hudson, Ia., as a substitute for Doctor Pettera last fall, will continue his medical practice at the Rib Lake clinic. Recently he was appointed to the board of directors of Memorial Hospital of Taylor County, Inc. to replace Doctor Pettera. With two other physicians, *Dr. Lester Nystrum* and *Dr. Walther Meyer,* Medford, he will serve in a medical advisory capacity and share one vote on the hospital board.

Dr. Brandabur Joins Madison Group

Dr. John J. Brandabur, Jr. has joined Associated Physicians in Madison for the practice of internal medicine. He was graduated in 1958 from the St. Louis University School of Medicine and interned at St. Mary's Hospital in Huntington, W. Va. Since 1959 he has been a resident in medicine at University Hospitals, Madison, where he was awarded the Rennebohm Research Fellowship in chest diseases. He has been a member of the 13th Evacuation Hospital Unit since 1959.

Dr. Olson Opens Schofield Office

Dr. M. H. Olson has opened a new medical office in the Schofield Clinic Building, where he will be closer to Wausau hospitals, and expects to divide his time between his Schofield and Wittenberg offices. Doctor Olson recently attended a meeting of the board of directors of the World Medical Association's United States Committee, of which he is a member.

Dr. Martens Joins Oregon Clinic

Dr. Jacob H. Martens, a native of New York, has become associated with *Drs. L. S. Kellogg* and *F. N. Dukerschein* in the Oregon Clinic at Oregon. Doctor Martens was graduated from the State University of New York, College of Medicine, in 1960. Between his third and fourth years in medical school he studied internal medicine for two months at the Middlesex Hospital Medical School, London, England, and spent two months at the Renal Clinic of the University at Lund, Sweden. Since July, 1961, Doctor Martens had been associated with the student health service at the University of Wisconsin and he has served as clinical instructor in medicine at the medical school. He is a diplomate of the National Board of Medical Examiners and is licensed in Wisconsin and New York.

Dr. Peterman Speaks in Texas

Dr. M. G. Peterman, Milwaukee, addressed the Texas Pediatrics Society July 25 at Port Arthur, Tex. His subject was "Tranquilizers in Pediatrics."

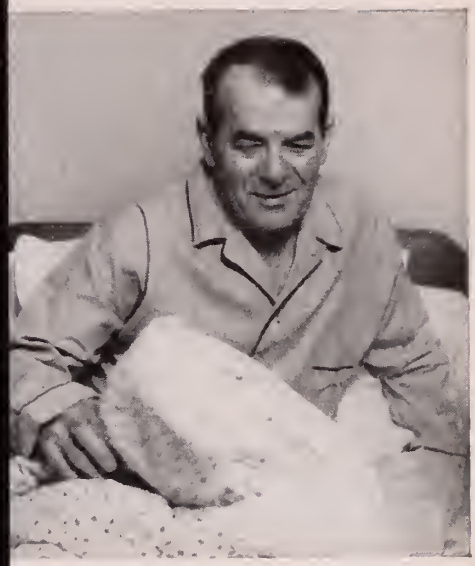
Dr. Turrell's Manuscript Published

"Private Psychiatric Hospitals," written by *Dr. Eugene S. Turrell,* Milwaukee, professor and chairman of the department of psychiatry, Marquette University School of Medicine, was published in the July, 1962, issue of HOSPITAL PROGRESS.

Dr. Damon Joins Waupun Clinic

Dr. Richard A. Damon has become a member of the Waupun Medical Clinic, it has been announced by *Dr. Harmon H. Hull* of the clinic. Doctor Damon is a graduate of the University of Iowa Medical School, an army veteran, and formerly was with the University of Michigan Student Health Service.

night, the arthritic wakes up comfortable



Morning stiffness may be reduced or even eliminated as a result of therapy with the only steroid in long-acting form. And the slow, steady release of steroid makes it possible in some cases to reduce the frequency of administration and/or the total daily steroid dosage.

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WISCONSIN PHYSICIANS *continued*

Marquette University Announces Appointments

Faculty promotions have been announced by Marquette University as follows:

Professors—*Drs. Harold F. Hardman,* pharmacology; *Edward T. Sheehan,* psychiatry; *John R. Amberg,* radiology; and *Raymond Headlee,* clinical professor of psychiatry.

Associate professor—*Drs. Helen Cooper Young,* pathology; *B. Cullen Burris* and *Max J. Primakow,* psychiatry; and Francis B. Landis, medicine.

Associate professor (part time)—*Drs. Robert D. O'Connor,* internal medicine; *Robert S. Haukohl,* pathology; and *William A. McClellan,* occupational and environmental medicine.

Associate clinical professor—*Drs. Stanley Berlow* and *Paul S. Pierson,* pediatrics; *Paul J. Lawler,* psychiatry; and *Paul J. Whitaker,* occupational and environmental medicine.

Assistant professor—*Dr. Louis T. Maxey,* pharmacology.

Assistant clinical professor—*Drs. Donald P. Babbitt,* radiology; *Barney B. Becker, Victor M. Bernhard, Frank E. Berridge, Jr., Wayne J. Boulanger, James H. Casey, Albert H. Pemberton,* and *Leo R. Weinshel,* surgery; *David V. Foley* and *William A. Kretzschmar,* obstetrics and gynecology; *Herbert G. Giller, Arthur C. Kissling, Jr., Brian C. McLaughlin, George J. Roncke, Arthur W. Tacke* and *Ralph E. Teitgen,* ophthalmology; *Richard A. Higley, Roger Laubenheimer* and *Gerald O. Stubenrauch,* dermatology; *Rex Ruppa,* pediatrics; *Ross R. Weller,* medicine; and *Carl Zenz,* occupational and environmental medicine.

Research Funds for Wisconsin

A portion of the $1,183,000 which the Life Insurance Medical Research Fund will give for heart research in the coming year will go to the University of Wisconsin. $38,500 will be allotted to Dr. H. G. Khorana for research on the chemistry and enzymology of polynucleotides. A postdoctoral fellowship for 1962–63 has been awarded to Philip Witonsky, Ph.D., New York, for study with Dr. Henry A. Lardy at the University.

Oconto Has New Doctor

Dr. Michael Barton, formerly on the staff at Veterans Administration Hospital in Poplar Bluff, Mo., has opened an office in Oconto. He is a graduate of the medical school at the University of Basel in Switzerland and did postgraduate work and residencies at Kansas City, Mo., Cleveland, Ohio, Philadelphia, Pa., Charleston, W. Va., and New York City.

Riverside Clinic Formed

Six Menasha physicians have combined their medical practices into a group to be known as the Riverside Clinic. They are *Drs. John E. Conway, George B. Hildebrand, William B. Hildebrand, George N. Pratt, Jr., George P. Schwei* and Thomas H. Alt. *Dr. David J. Buran,* who has been associated with the medical group for the last two years, will return to Riverside Clinic upon completion of a residency in otolaryngology at the University of Minnesota Hospitals, Minneapolis.

Dr. Kuhs Wins Art Recognition

Dr. M. L. Kuhs, Green Bay, won recognition for his oil still life painting in the 25th annual exhibit of the American Physicians' Art Association at the American Medical Association annual meeting in June. He was one of 57 award winners selected from among more than 500 entries.

Knights of Columbus Hear Dr. Healy

Dr. J. P. Healy, New Richmond, talked to approximately 100 Knights of Columbus members and their families recently on the King-Anderson medicare bill. He asked them to let their congressmen know their sentiments on the bill.

S. A. Morton, M.D.

Robert W. Byrne, M.D.

Hospital Staff Honors Dr. Morton

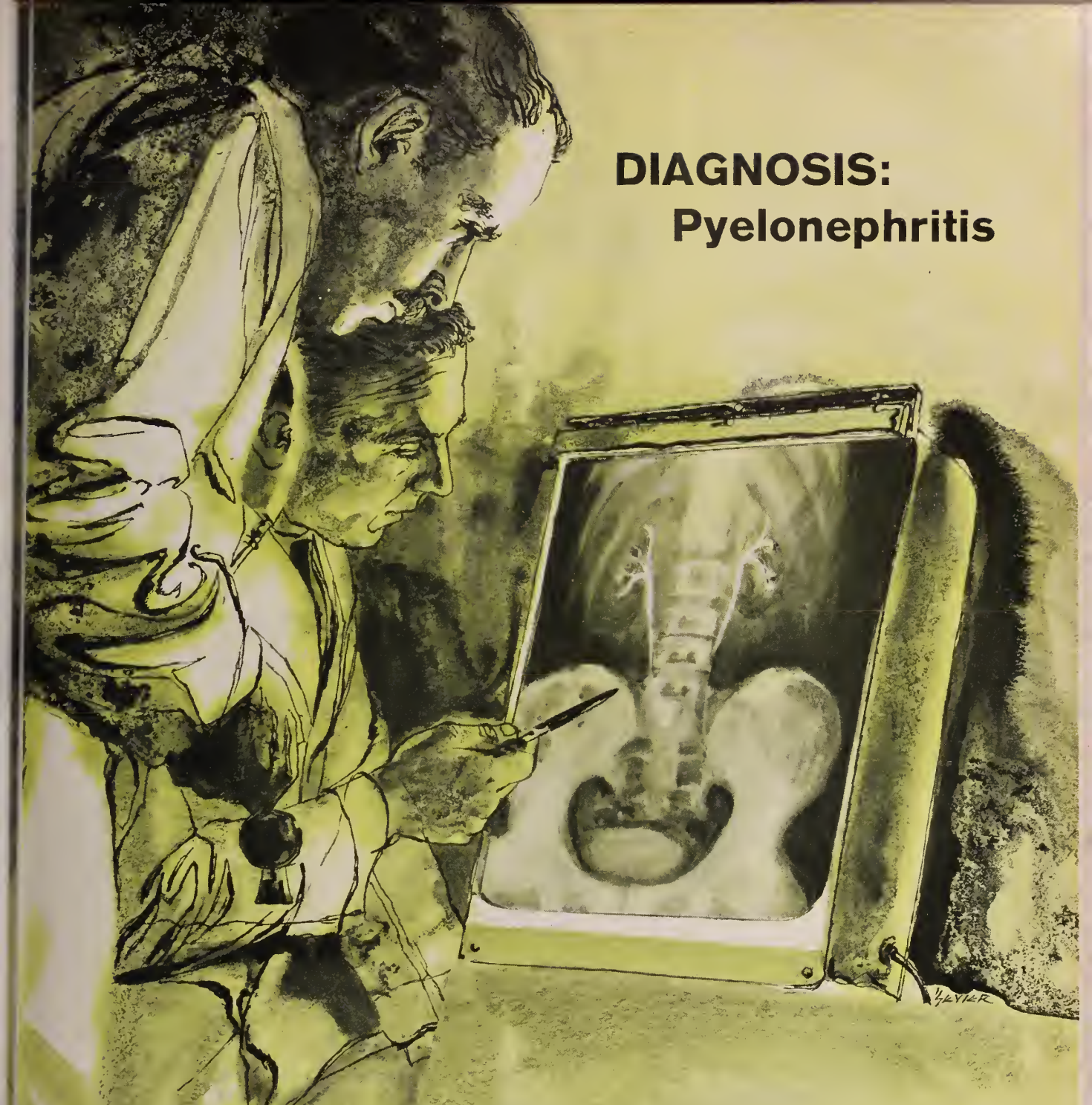
The Columbia Hospital medical staff honored *Dr. S. A. Morton,* Milwaukee, at a dinner at the University Club in Milwaukee late last spring in recognition of his 30 years as chief of radiology at the hospital. He recently stepped down from that post and has been succeeded by *Dr. Robert W. Byrne.*

Waukesha Hospital Announces Appointments

The Waukesha Memorial Hospital Board has approved the transfer of *Dr. J. R. Hoffman,* Menomonee Falls, from the temporary to the associate staff in internal medicine and has appointed *Dr. Martin Z. Fruchtman,* Waukesha, to the temporary staff in internal medicine.

Dr. Salibi Talks at Stanley

Dr. Bahij Salibi of the Marshfield Clinic, was the guest speaker at the hospital medical staff meeting of Victory Memorial Hospital in Stanley late in June. Members of the registered nurses staff were guests.



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WISCONSIN PHYSICIANS *continued*

Specialists Join Marshfield Clinic

Dr. N. A. Moffat, specialist in urology, and Dr. George L. River, specialist in internal medicine, have joined the Marshfield Clinic.

Doctor Moffat, a Californian, was graduated from Culver Military Academy in Culver, Ind.; attended Princeton University for three years, and was graduated from the University of Chicago School of Medicine in 1955. He interned at Minneapolis General Hospital, and after two years of Army duty, he took a residency in urology at Duke University, which he finished in July.

Doctor River, a native of Illinois, was graduated from University of Chicago High School in 1949, received his B.A. degree from the University of Chicago in 1952, and was graduated from the Stritch School of Medicine at Loyola University in 1956. He interned and took three years of resident work in internal medicine at the Cook County Hospital in Chicago, and for the last two years has been serving the Air Force at Lackland Air Force Base in Texas.

Platteville Holds Mental Health Day

Dr. Robert O'Connor, superintendent of the Wisconsin Diagnostic Center at Madison, spoke at Grant county's sixth annual Mental Health Day at Platteville in July.

Honored for 25 Years' Practice

Dr. Joseph Miller, who has practiced medicine in Mt. Calvary for 25 years, was feted by more than 1,000 friends at a community dinner at Mt. Calvary in July.

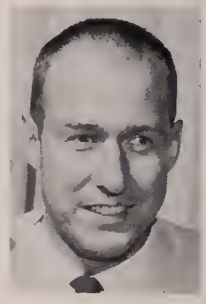
Dr. Schoenbeck Joins Father

Dr. Philip Schoenbeck has come from New Orleans, La., where he has completed four years of residency in general surgery at the Veterans Administration Hospital, to join his father, *Dr. Robert Schoenbeck,* in the practice of medicine in Stoughton.

Dr. Dibble Serves in Africa

Dr. J. Birney Dibble, has terminated his practice in Eau Claire for a year and, with his wife and two young children, has left for medical missionary work in Africa. He is practicing in a 100-bed hospital in Kiomboy, Tanganyika, Africa, a village of a few hundred residents.

Doctor Dibble was born in India where his father was in the mission field. Knowing the needs of a mission hospital through his background, Doctor Dibble has gone to Africa because it is something he "wants to do and has to do."



J. B. Dibble, M.D.

Having given up a surgeon's income for a year, Doctor Dibble hopes to make expenses with his missionary work. Instead of their two-story colonial home in Eau Claire, his family is living in a stone house with mud brick lining in a community which has 10 white residents, including 5 nurses, 3 teachers and another doctor and his wife. Eric, 7, will attend a modern school with an enrollment of some 80 white pupils, but Barbara, 5, for lack of a kindergarten, will be taught by her mother.

Medical Aspects of Sports Presented

Dr. James C. H. Russell, Fort Atkinson, addressed the national convention of the National Federation of High School Athletic Associations in Saskatoon, Saskatchewan, Canada, in July. He spoke to 600 delegates on "Some Medical Aspects of Sports."

Doctor Russell is president of the Fort Atkinson Board of Education, team physician for the high school, and a member of the medical advisory board of the Wisconsin Interscholastic Athletic Association.

New Hospital Sign Donated

Dr. E. M. Houghton, Lancaster, has donated a new entrance sign to the Memorial Hospital, Prairie du Chien.

Distributors for
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x-ray equipment—accessories
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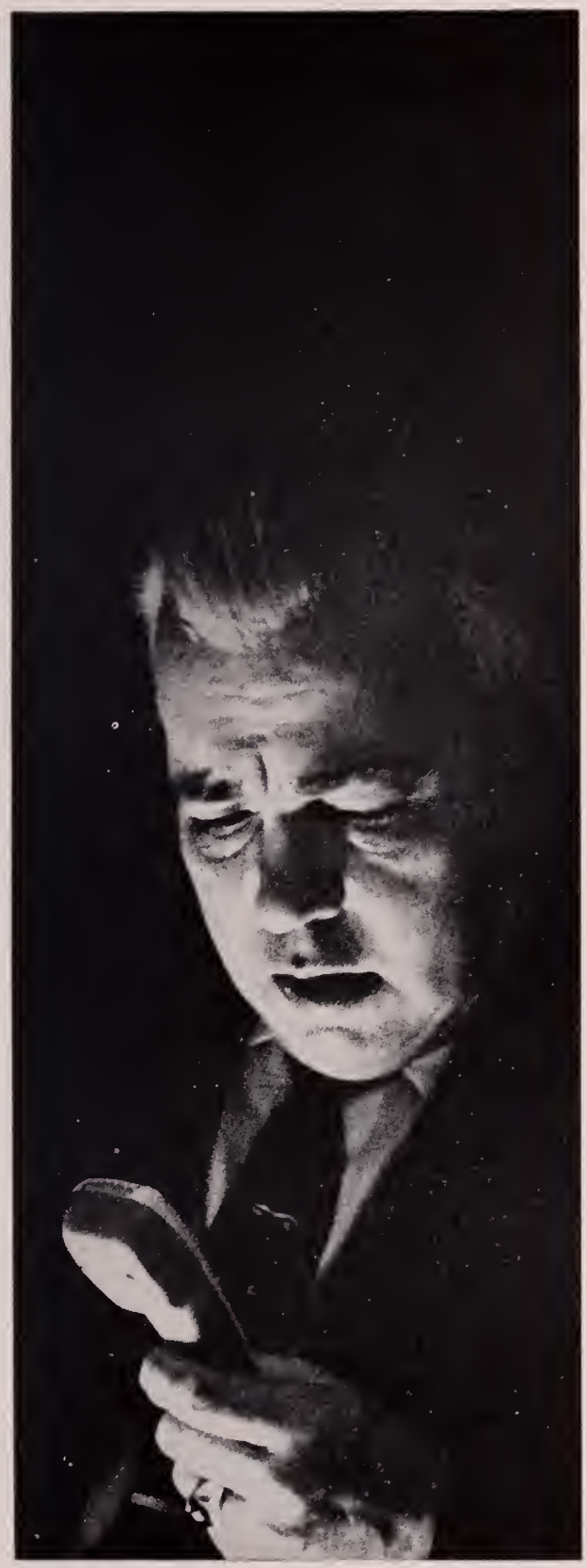

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New Isuprel Compound Elixir is a balanced expectorant bronchodilator. It contains potassium iodide to promote expectoration and relieve dry cough. Its three bronchodilators, Isuprel, ephedrine, and theophylline, keep bronchi continuously dilated. Luminal is included to negate possible side effect from adrenergic medication and to provide very mild sedation for the patient.

New Isuprel Compound Elixir alleviates symptoms...prolongs relief in chronic bronchitis and emphysema.

Each good-tasting vanilla-flavored tablespoon (15 cc.) contains:

Isuprel® (brand of isoproterenol) HCl	2.5 mg.
Ephedrine sulfate	12 mg.
Theophylline	45 mg.
Potassium iodide	150 mg.
Luminal® (brand of phenobarbital)	6 mg.
Alcohol	19%

Adult Dose: 2 tablespoons 3 or 4 times daily.

How Supplied: Isuprel Compound Elixir is supplied in bottles of 16 fl. oz.

Before prescribing be sure to consult Winthrop's literature for additional information about dosage, possible side effects and contraindications.

New ISUPREL® compound ELIXIR

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New York 18, N.Y.

ISUPREL AND LUMINAL, TRADEMARKS REG. U. S. PAT. OFF.

WISCONSIN PHYSICIANS *continued*

Neenah Physicians Named Diplomates

Dr. Walter R. Hathaway, a staff physician at Theda Clark Memorial Hospital in Neenah, has been named a diplomate of the American Board of Pathology. *Dr. Ralph L. Suechting,* who is associated with *Dr. Raymond Quade* in Neenah, has been named a diplomate of the American Board of Neurosurgery. He also has a fellowship in the Congress of Neurological Surgery and in the Central Neurological Society.

Attend Navy Medical Forum

Lt. Cmdr. B. H. Glover, M.D., and *Lt. C. C. Knight, M.D.,* of the United States Naval Reserve Medical Corps, both of Madison, attended a combined medical seminar at Great Lakes, Ill., recently. Doctor Glover, who is with the department of psychiatry at University Hospitals, and Doctor Knight, who is with the department of anesthesiology there, help recruit medical students interested in a Navy internship.

Dr. Griffin Outlines Hospital Expansion

Dr. V. M. Griffin, chief of staff of the Hess Memorial Hospital at Mauston, recently addressed a special meeting of citizens served by the hospital on the need for a $418,000 hospital expansion program.

Discusses Open Heart Surgery

Dr. Richard D. Sautter, of the Marshfield Clinic, told Marshfield Kiwanians at their August meeting about open heart surgery performed in Marshfield's St. Joseph's Hospital. Doctor Sautter was introduced by *Dr. Francis Kruse,* Marshfield.

Capt. Hepperla Resumes Practice

Capt. Roger L. Hepperla, commanding officer and anesthesiologist for Fort Ord's 115th Medical Detachment, returned to Milwaukee this month after his reserve unit was released from active duty August 1. He will resume his civilian life as an anesthesiologist at Columbia Hospital.

Dr. Cooper Attends Dermatology Meeting

Dr. G. A. Cooper, Madison, attended the International Congress of Dermatology held September 9–15 in Washington, D. C. He and his wife toured the Smokie Mountain area before returning home on September 25.

Dr. Uecker Returns to Wausau

Dr. Ronald L. Uecker returned to his native Wausau September 1 as head of the department of radiology at Wausau Memorial Hospital. He succeeds *Dr. Helen Crawford Davis* who retired recently.

A graduate of the University of Wisconsin Medical School in 1958, Doctor Uecker spent his internship in Portland, Ore., returning to University Hospitals, Madison, for specialty training which he completed in July of this year.

Participate in Chicago Symposium

Several Wisconsin physicians will play a part in the 47th Scientific Assembly of the Interstate Postgraduate Medical Association in Chicago October 4.

Drs. Edwin H. Ellison and *F. Jackson Stoddard,* Milwaukee, will participate in a Cancer Detection "Round-Up" on October 4.

Dr. John D. Hurley, Milwaukee, and *Dr. Anthony R. Curreri,* Madison, will take part in a teaching program on "Chemotherapy Agents of Promise in the Control of Cancer" on October 3.

Dr. Edgar S. Gordon, Madison, will moderate a panel discussion of "Is There Really Anything New in Diabetes for the GP?" on October 1. *Dr. John Rankin,* Madison, will talk on "Treatment of Pulmonary Emphysema and Related Conditions" in a teaching program scheduled the same day.

Dr. Frank Discusses Medicare Programs

Dr. Ralph Frank, Eau Claire, addressed the Eau Claire Lions Club in July and the Eau Claire Exchange Club in August on the Senate-defeated King–Anderson bill and the Kerr–Mills law. (Details of his remarks appear elsewhere in this issue.)

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Society Records

Membership Report as of July 31, 1962

NEW MEMBERS

Hugo M. Bachhuber, Box H, Winnebago.
James E. Bell, 8700 West Wisconsin Avenue, Milwaukee.
James F. Berg, 8410 West Cleveland Avenue, Milwaukee.
John J. Brady, 409 East Silver Spring Drive, Whitefish Bay.
John J. Brandabur, 1922 University Avenue, Madison.
Rodney B. Fruth, 111 East Wisconsin Avenue, Milwaukee.
H. James Hamm, 2200 West Kilbourn Avenue, Milwaukee.
Eugene R. Jonas, 111 Chestnut Street, Ellsworth.
James R. Keuer, 101 North Gibson Avenue, Medford.
Hooshang Khajezadeh, 6030 West Capitol Drive, Milwaukee.
E. Gerald Luthers, 3333 South 27th Street, Milwaukee.
Sanford R. Mallin, 425 East Wisconsin Avenue, Milwaukee.
John A. May, Baldwin Clinic, Baldwin.
David J. Ottensmeyer, 1005 Lorraine Drive, Madison.
Joseph M. Pawlowski, 8700 West Wisconsin Avenue, Milwaukee.
Ruth S. Rinder, 2577 North Downer Avenue, Milwaukee.
Phillip J. Schoenbeck, 101 East Main Street, Stoughton.
Donald F. Schwab, 3414 Monroe Street, Madison 11.
Thomas R. Simon, 8700 West Wisconsin Avenue, Milwaukee.
Sherwood B. Stolp, 5810 West Oklahoma, Milwaukee.
James S. Ziolkowski, 2212 West State Street, Milwaukee.

CHANGES OF ADDRESS

Street Address Changes

I. M. Becker, to 2040 West Wisconsin Avenue, Milwaukee 3.
J. H. Becker, to 413 Main Street, Watertown.
M. M. Bortin, to 2040 West Wisconsin Avenue, Milwaukee 3.
Christo Christoff, to 424 North Pinckney Street, Madison 3.
Thomas E. Dugan, to 336 West Wisconsin Avenue, Waukesha.
T. D. Elbe, to 143 Green Bay Road, Thiensville.
H. R. Foerster, to 740 Marine Plaza, Milwaukee 2.
H. R. Foerster, Jr., to 740 Marine Plaza, Milwaukee 2.
O. H. Foerster, to 740 Marine Plaza, Milwaukee 2.
R. S. Galgano, to 610 Walworth, Delavan.
James A. Groh, to 4036 North 51st Boulevard, Milwaukee 16.
F. C. Heinan, to 7635 West Oklahoma Avenue, Milwaukee.
W. J. Houghton, to 2943 North Oakland Avenue, Milwaukee 11.
Lawrence A. Howards, to 7044 North 38th Court, Milwaukee.
Ronald C. Johnson, to 8511 West Lincoln Avenue, Milwaukee.
C. A. Kemper, to 727 Maple Street, Chippewa Falls.
Howard M. Klopf, to 3615 West Oklahoma Avenue, Milwaukee.
Kenneth R. Knutson, to 2311 Elmwood Boulevard, Wausau.
John C. McAleavy, to 306 Cheyenne Trail, Madison.
T. J. Nereim, to 222 North Midvale Boulevard, Madison 5.
L. W. Picotte, to 600 Bay Street, Chippewa Falls.
R. B. Pittelkow, to 740 Marine Plaza, Milwaukee 2.
D. M. Ruch, to 740 Marine Plaza, Milwaukee 2.
W. E. Scheuenemann, to 824 West Badger Lane, West Bend.
K. M. Smigielski, to 3615 West Oklahoma Avenue, Milwaukee.
Donald P. Ullrich, to 6001 West Center Street, Milwaukee 10.
V. N. Vitulli, to 4114 South Pine Avenue, Milwaukee 7.
K. B. Witte, to 2178 20th Avenue, Monroe.

City Address Changes

John Arkins, Fort Lewis, Washington, to 1212 West Wisconsin Avenue, Milwaukee.
Frederick Bauer, Algonquin, Illinois, to 924 North Seminary Avenue, Woodstock, Illinois.
Edward J. Beil, Wood, to 11801 Indian Trail, Hales Corners.
Roland E. Berry, Wood, to V. A. Hospital, Iron Mountain, Michigan.
Stanley L. Betts, Merrill, to 5151 State College Drive, Los Angeles 32, California.
I. L. Blose, Durand, to 103 South 51st Street, Omaha, Nebraska.
John Z. Bowers, Madison, to c/o Dr. Lloyd Florio, U. S. Overseas Mission, APO 928, San Francisco, California.
John J. Czajka, Milwaukee, to 5636 South 108th Street, Hales Corners.
Richard A. Eckberg, Madison, to 133 Martin Road, Waterloo, Iowa.
Eugene H. Ephron, Duarte, California, to 3670 Clairemont Drive, San Diego, California.
Jordon Frank, Madison, to 431 Olympian Boulevard, Beloit.
D. A. Franklin, Milwaukee, to 2508 North Vermont Avenue, Hollywood, California.

SOCIETY RECORDS *continued*

Gregory L. Gallo, Oconomowoc, to 5209 Burnett Drive, Madison 5.

Michael T. Jaekels, Park Forest, Illinois, to 7614 North Bell Road, Milwaukee 17.

Jerry H. Jascula, Milwaukee, to 2200 Hayes Street, San Francisco 17, California.

G. M. Kroncke, Charleston, South Carolina, to 425 Rushmore Lane, Madison.

Henry C. LaBrec, Milwaukee, to 2210 South 23rd Street, La Crosse.

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Paul Lucas, Battle Creek, Michigan, to 7330 West Eden Place, Milwaukee 20.

Frank A. Luckay, Milwaukee, to 1465 Miami, Corpus Christi, Texas.

Don H. Martin, Fox Point, to 8029 West Burleigh, Milwaukee.

Marcial E. Martinez, Milwaukee, to 214 Steeplechase Drive, Racine.

J. R. McKenzie, Jr., Rice Lake, to 15065 Carpenter Road, Brookfield.

John R. Pellett, Madison, to 253-S South Point Road, Route 1, Verona.

J. A. Peterson, Honolulu, Hawaii, to Hermann Hospital, Houston, Texas.

Robert W. Schmitt, Topeka, Kansas, to 54 South 15th Street, Richmond, Indiana.

Rudolph J. Scrimenti, Philadelphia, Pennsylvania, to United States Naval Reserve, Guantanamo Bay, Cuba.

David Shapiro, Appleton, to 3210–8th Street South, Wisconsin Rapids.

Paul O. Simenstad, Minneapolis, Minnesota, to Osceola.

Theodore C. Smith, Portsmouth, Virginia, to University Hospitals, Philadelphia 4, Pennsylvania.

James J. Tisone, Wood, to 6070 North Alberta Lane, Milwaukee 17.

S. P. Vinograd, Rockville, Maryland, to 1806 East La Rua Drive, Pensacola, Florida.

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MEDICAL STAFF

William L. Herner, M. D., Medical Director
John F. Wyman, M. D.
Hubert H. Blanchard, M. D.
John E. Leach, M. D.
Lloyd F. Jenk, M. D.
Preston W. Thomas, M. D.
William H. McCreary, Jr., M. D.

CALENDAR OF MEETINGS

Wisconsin

1962

Oct. 2: Conference on Occupational Noise, Mount Sinai Hospital, Milwaukee.

Oct. 4: Postgraduate Course on Diagnostic and Therapy Problems Commonly Occurring in General Practice, University of Wisconsin Medical School, Madison.

Oct. 15–19: Postgraduate Course on Biologic Foundations for the Medicine of Tomorrow, American College of Physicians, University of Wisconsin, Madison.

Oct. 18: SMS teaching program on Clinical Electrocardiography, St. Joseph's Hospital, Dodgeville.

Oct. 19–21: Postgraduate Course on Recent Concepts in Radiology, Marquette University School of Medicine, Milwaukee.

Oct. 20: Cancer Scrimmage, UW, Madison.

Oct. 23–25: SMS one-day teaching program on "Strokes —What Can We Do About Them?", (23) Pine Hills Country Club, Sheboygan. (24) Wausau Club, Wausau. (25) Eau Claire Hotel, Eau Claire.

Oct. 26–27: Joint meeting, North Central Section of the College of American Pathologists and the Wisconsin Society of Pathologists, at Marquette U., Milwaukee.

Nov. 1: Postgraduate Course on Surgical Emergencies Confronting the General Practitioner, University of Wisconsin Medical School, Madison.

Nov. 8: SMS teaching program on Clinical Electrocardiography, St. Mary's Hospital, Rhinelander.

Nov. 14–15: Scientific meeting of The Medical Society of Milwaukee County, Milwaukee.

Nov. 15: SMS teaching program on Clinical Electrocardiography, Lakeside Methodist Hospital, Rice Lake.

Dec. 12–13: Postgraduate Course on the Nonoperative Therapy of Malignancy, Marquette University School of Medicine, Milwaukee.

Out-of-State

Sept. 23–28: Annual meeting of the Michigan State Medical Society, Sheraton-Cadillac Hotel, Detroit.

Oct. 1–4: 47th Scientific Assembly of the Interstate Postgraduate Medical Association, Palmer House, Chicago.

Oct. 5–6: Postgraduate course on Arthritis and Related Disorders, University of Iowa College of Medicine, Iowa City.

Oct. 8–10: Third annual program conference of the National Association of Blue Shield Plans, Americana Hotel, Miami Beach, Florida.

Oct. 13: Postgraduate course on Radiology, University of Iowa College of Medicine, Iowa City.

Oct. 15–19: Clinical Congress of American College of Surgeons, Atlantic City, N. J.

Oct. 15–19: Annual meeting of the American Public Health Association, Fountainbleau Hotel, Miami Beach, Florida.

Oct. 15–19: 11th annual conference of United States Civil Defense Council, James White Memorial Auditorium Coliseum at Knoxville, Tennessee.

Oct. 20–22: American Society of Anesthesiologists annual meeting, Statler Hilton Hotel, New York.

Oct. 26–28: Annual Scientific Sessions of American Heart Association, Public Auditorium, Cleveland, Onio.

Oct. 29–31: Annual convention of the American College of Gastroenterology, Morrison Hotel, Chicago.

Oct. 29–Nov. 2: Postgradaute course, The Rheumatic Diseases—Pathology, Diagnosis and Treatment, American College of Physicians, Harvard Medical School, Boston, Mass.

Nov. 1–2: American Rhinologic Society annual meeting, Statler Hilton Hotel, Los Angeles.

Nov. 1–3: Academy of Psychosomatic Medicine annual meeting, Radisson Hotel, Minneapolis, Minn.

Nov. 1–3: Annual Course in Postgraduate Gastroenterology of the American College of Gastroenterology, Morrison Hotel, Chicago.

Nov. 9: Annual symposium, Diabetes Association of Greater Chicago, Passavant Memorial Hospital, Chicago.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California

Medical Meetings

Postgraduate Courses

Symposium on Occupational Noise

Mount Sinai Hospital, Milwaukee, will hold a special one-day Conference on Occupational Noise October 2. The symposium will be presented by the department of otolaryngology with Dr. Meyer S. Fox, chief of the department, as chairman.

The conference is planned for industrial executives, physicians, safety personnel, industrial nurses and others who are concerned with problems of occupational noise.

Conference speakers and their subjects include:

"Fifteen Years Experience with the Industrial Noise Problems," by James F. Dinneen, legal counsel for the Liberty Mutual Insurance Company, Boston, Mass.

"Facts and Fallacies Regarding Noise and Hearing Loss," by Dr. Aram Glorig, director of research for the American Academy of Ophthalmology and Otolaryngology, Los Angeles.

"Recommendations for Practical and Realistic Hearing Conservation Programs in Industry," by Dr. Ellis Singer, Industrial Acoustics Company, Inc., New York.

"Teamwork Approach to the Industrial Noise Problem," by Walter Scholtz, supervisor of Industrial Hygiene, Allis-Chalmers Manufacturing Company, Milwaukee.

"Experience with Hearing Conservation Programs —Critique of Medical Efforts and Accomplishments," by Dr. Meyer S. Fox, chief of ear, nose and throat department, Mount Sinai Hospital and member of the subcommittee on noise of the American Academy of Ophthalmology and Otolaryngology.

"Compensation Aspects of the Hearing Loss Problem in Wisconsin and in the United States," by Mr. Ralph E. Gintz, director of Workmen's Compensation Division of the Wisconsin Industrial Commission.

Registration and fee of $10, which includes lunch, should be sent in advance to the Medical Staff Secretary, Mount Sinai Hospital, 948 N. 12th Street, Milwaukee. Only advance registrations will be admitted.

Marquette University Postgraduate Course

Marquette University School of Medicine in cooperation with the Milwaukee County Hospital will present a postgraduate course in "Radiology (for nonradiologists)" on October 19, 20 and 21 at the Coach House Motor Inn, 1926 West Wisconsin Avenue, Milwaukee.

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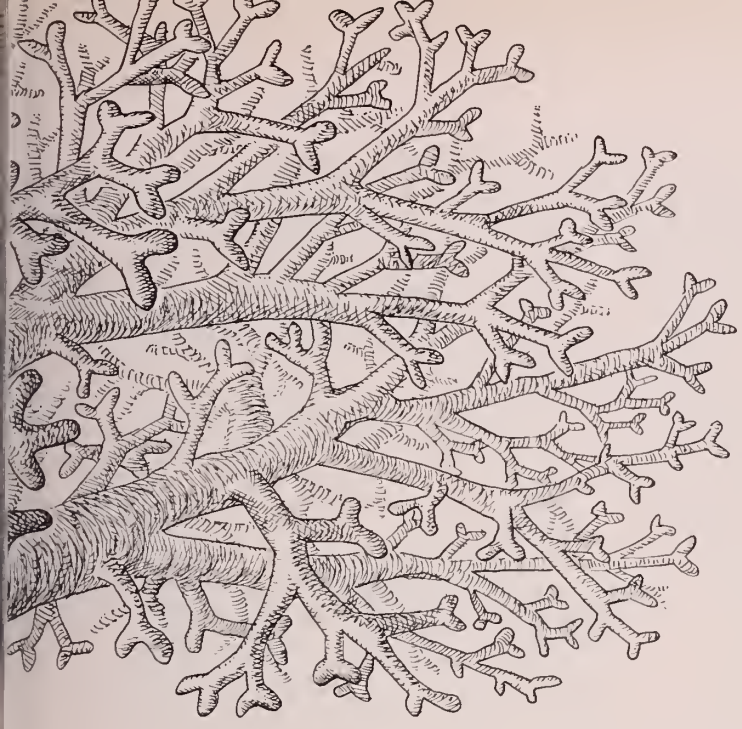

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MEDICAL MEETINGS *continued*

Sessions will be: Friday, Oct. 19, 9 a.m. to 5 p.m.; Saturday, Oct. 20, 9 a.m. to 12 noon, and Sunday, Oct. 21, 11 a.m. to 12 noon.

The Sunday meeting will end in time to attend the Green Bay Packers vs. San Francisco 49ers football game at Milwaukee County Stadium.

Director of the course is Dr. John R. Amberg, professor and chairman of the division of radiology, Marquette University School of Medicine.

Reservations should be made with Joseph W. Rastetter, M.D., director of postgraduate Medical Education Programs, 8700 W. Wisconsin Ave., Milwaukee 13, Wis.

University of Iowa Postgraduate Courses

A postgraduate course on "Arthritis and Related Disorders" will be held at the University of Iowa College of Medicine, Iowa City, October 5 and 6. Dr. Janet Travell, personal physician to President John F. Kennedy, will discuss "Management of Referred Skeletal Pain." Other guest faculty members will be Dr. L. Maxwell Lockie, professor of therapeutics, University of Buffalo, and Dr. Max M. Montgomery, associate professor of medicine, University of Illinois.

A postgraduate conference on Radiology will be held at the University of Iowa on October 13.

Physicians who would like to receive programs and registration materials may write to John A. Gius, M.D., Director, Postgraduate Medical Studies, Office of the Dean, College of Medicine, Iowa City, Iowa.

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Michigan State Medical Society

The 97th annual session of the Michigan State Medical Society will be held September 23 to September 28 at the Sheraton-Cadillac Hotel, Detroit. The Woman's Auxiliary to the Michigan State Medical Society will hold its 36th annual convention simultaneously at the Pick-Fort Shelby Hotel, Detroit.

American College of Physicians

Postgraduate courses for the fall season have been scheduled by the American College of Physicians as follows:

Difficult Contemporary Problems in Internal Medicine, University of Oregon Medical School, Portland, Oregon, October 1–5.

Basic Mechanisms in Internal Medicine, Medical College of Virginia School of Medicine, Richmond, Virginia, October 1–5.

Advances in the Medical Aspects of Cancer, Memorial Sloan-Kettering Cancer Center, New York, N. Y., October 8–12.

Biologic Foundations for the Medicine of Tomorrow, University of Wisconsin Medical School, Madison, Wisconsin, October 15–19.

The Rheumatic Diseases—Pathology, Diagnosis and Treatment, Robert B. Brigham Hospital and Peter Bent Brigham Hospital, Boston, Massachusetts, October 29 to November 2.

Endocrinology and Metabolism, The Johns Hopkins Hospital, Baltimore, Maryland, November 13–17.

Psychiatry for the Internist, University of Southern California, Los Angeles, California, December 3–7.

In "Biologic Foundations for the Medicine of Tomorrow," to be held in the Wisconsin Center at the University of Wisconsin, certain fundamental concepts which are on the verge of clinical application will be presented to the internist.

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*Schwartz, I. R.:
Current Therap. Res. 3:29, Feb., 1961.

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MEDICAL MEETINGS *continued*

Monday morning will be devoted to hematology, the afternoon to protein metabolism; Tuesday morning to catacholamines, noon session, panel on the same subject, and the afternoon to cardiovascular diseases; Wednesday, to pulmonary physiology, with a panel at noon; Thursday morning will be devoted to the McArdle Laboratory for Cancer Research, with noon panel, while the afternoon will cover endocrinology; Friday morning, genetics, plus a panel at noon on this subject, and tryptophan in the afternoon.

Direct inquiries for further information to Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

National Association of Blue Shield Plans

The third annual program conference of Blue Shield Plans will be held October 8 to 10 at the Americana Hotel in Miami Beach, Florida, the National Association of Blue Shield Plans has announced.

Dr. Edward R. Annis, president-elect of the American Medical Association, will be one of the featured speakers at the three-day conference which has as its theme "Achieving Improved Performance."

American Public Health Association

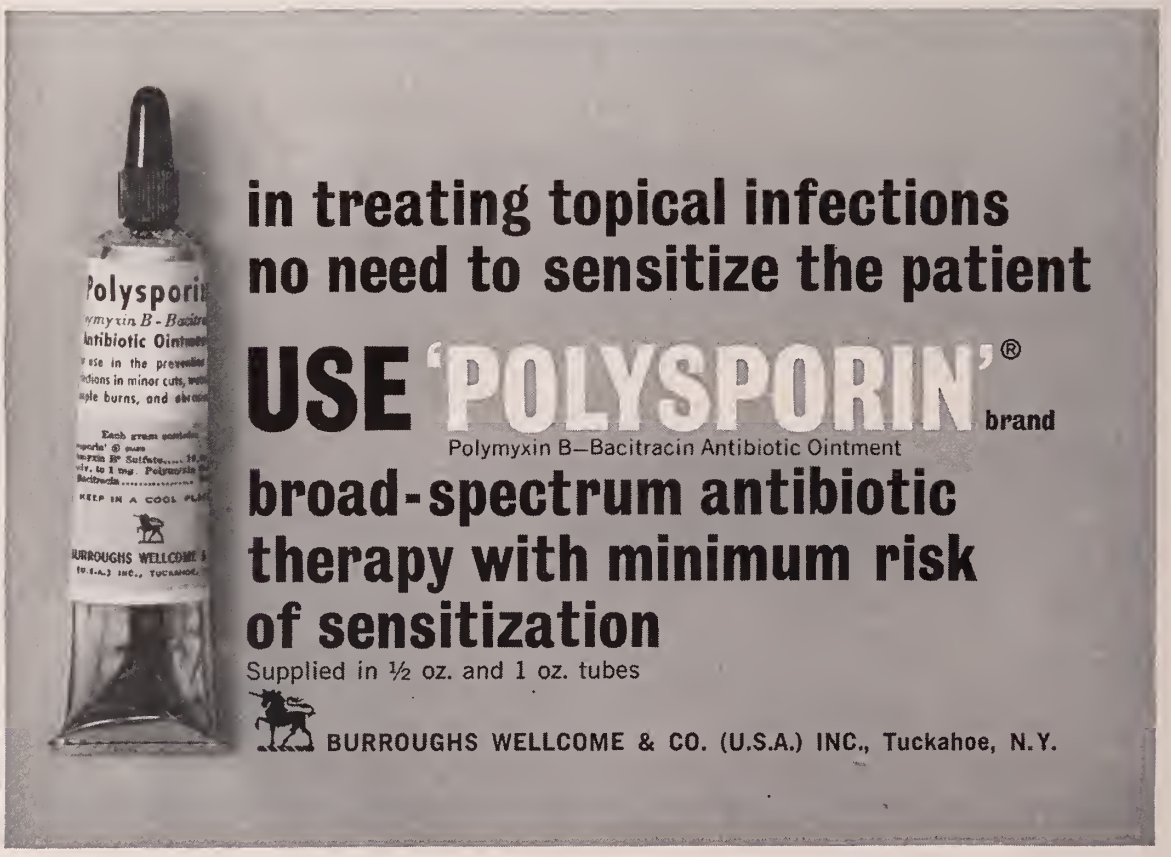
More than 6,000 public health practitioners are expected to attend the 90th annual meeting of the American Public Health Association at the Fountainebleau Hotel in Miami Beach October 15–19. Meeting with the Association will be more than 60 related organizations—alumni groups of schools of public health, voluntary health organizations and associations representing specialties within public health.

New York Academy of Sciences

"Fetal and Infant Liver Function and Structure" is the topic of the conference which the New York Academy of Sciences will sponsor at the Henry Hudson Hotel, New York City, November 7–10. Invitations may be obtained from Mrs. E. T. Minor, Executive Secretary of the New York Academy of Sciences, 2 East Sixty-Third Street, New York 21, N. Y.

United States Civil Defense Council

The 11th annual conference of the United States Civil Defense Council will be held October 15–19 in the James White Memorial Auditorium-Coliseum at Knoxville, Tennessee. Participating in the program of the health services advisory committee will be Dr. Robert J. Samp, Madison, associate profes-



sor, department of surgery, Cancer Research Division and Clinical Cancer, University of Wisconsin. Doctor Samp will moderate a panel discussion on "Requirements of Health Services in Civil Defense and Disaster Preparedness Emergencies."

Interstate Postgraduate Medical Association

The Interstate Postgraduate Medical Association will hold its 47th scientific assembly at the Palmer House in Chicago October 1–4. The program, which is supported in part by the Merck Sharp & Dohme Postgraduate Program, will be acceptable for a maximum of 20½ hours of Category II credit by the American Academy of General Practice.

Wisconsin physicians participating in the scientific assembly include Drs. Edgar S. Gordon, John Rankin, and Anthony R. Curreri, Madison, and John D. Hurley, F. Jackson Stoddard, and Edwin H. Ellison, Milwaukee.

Gen. Alfred M. Gruenther, president of the American National Red Cross, Washington, D. C., will speak on "American Problems In An Uneasy World" at the banquet.

Southern Medical Association

The section of Ophthalmology of the Southern Medical Association has announced that Dr. Arthur Gerard DeVoe of New York City will be the guest speaker at their annual meeting at the Fontainebleau Hotel in Miami Beach, Fla., November 12–15, the week following the Academy meeting.

For further information, contact the Secretary, Albert C. Esposito, M.D., Suite 1212, First Huntington National Bank Building, Huntington, W. Va.

Diabetes Association of Greater Chicago

The Diabetes Association of Greater Chicago will conduct its Sixth Annual Symposium on Diabetes at the Offield Auditorium, Passavant Memorial Hospital, 303 East Superior Street, Chicago, on Friday, November 9.

Dr. Edgar Gordon, University of Wisconsin Medical School, is one of the speakers.

Registration is free for members of the Diabetes Association of Greater Chicago and for medical students and resident house staff members. The fee for nonmembers is $25.

This symposium is acceptable for eight hours of Category II credit by the American Academy of General Practice.

American College of Gastroenterology

The 27th annual convention of the American College of Gastroenterology will be held at the Morrison Hotel in Chicago October 29–31.

On November 1, 2, 3, immediately following the convention, Dr. Owen H. Wangensteen, Minneapolis, Minn., and Dr. I. Snapper, Brooklyn, N. Y., will again moderate the annual course in Postgraduate Gastroenterology. The sessions will be held at the Morrison Hotel and the Cook County Hospital. Attendance will be limited to those who have registered in advance.

The program and further information may be obtained from the American College of Gastroenterology, 33 West 60th St., New York 23, N. Y.

Wisconsin Postgraduate Courses

The following courses are being offered by the University Postgraduate Program in Medical Education. They will be held at University Hospitals, Madison, and each session of both courses have been awarded four hours of Category I credit by the Academy of General Practice.

Oct. 4: The Patient Who Bleeds from Nowhere

Nov. 1: Surgical Emergencies Confronting the General Practitioner

Omaha Mid-West Clinical Society

The 30th Annual Postgraduate Medical Assembly of Omaha Mid-West Clinical Society will meet in Omaha's civic auditorium October 29 through November 1. The 1962 program is acceptable for 32 hours Category I credit to members of the American Academy of General Practice. The Assembly is presented under the co-sponsorship of Creighton and Nebraska Colleges of Medicine, and the Nebraska Chapter of American Academy of General Practice.

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Surgical Technic, Two Weeks, November 5
Surgery of Colon and Rectum, One Week, November 26
Surgery of Stomach and Duodenum, One Week, September 24
Vaginal Approach to Pelvic Surgery, One Week, October 1
Gynecology, Office and Operative, Two Weeks, November 5
Obstetrics, General and Surgical, Two Weeks, October 8
Urology, Two Weeks, October 29
Proctoscopy and Sigmoidoscopy, One Week, October 29
General Practice Review, One Week, October 8
Gallbladder Surgery, 3 Days, October 8
Surgery of Hernia, 3 Days, October 11
Basic Electrocardiography, One Week, October 1
Advances in Medicine, One Week, October 15
Advances in Surgery, One Week, December 10
Blood Vessel Surgery, One Week, October 22
Board of Surgery Review, Part I, Two Weeks, November 5
Board of Surgery Review, Part II, Two Weeks, November 26
Clinical Uses of Radioisotopes, Two Weeks, October 1
Treatment of Varicose Veins, One Week, October 29
Information concerning numerous other continuation courses available upon request.

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Chicago 12, Illinois

MEDICAL MEETINGS *continued*

Medical College of Georgia Course

The Medical College of Georgia's Department of Continuing Education has planned a series of five intensive postgraduate courses for the fall and winter 1962–1963.

Clinical Pathology in Medical Practice, October 23–25.

Diagnosis and Practical Management of Arthritis, November 13–15.

Orthopedics in General Practice, December 4–6.

Growth and Development—Management of Common Behavior Disturbances, February 12–14, 1963.

Gynecologic Problems in Private Practice, March 12–14, 1963.

Each course is acceptable for 18 hours credit by the American Academy of General Practice. Application may be made by contacting Dr. Claude–Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta, Ga.

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CLINICAL ELECTROCARDIOGRAPHY

DODGEVILLE: Thursday, October 18, St. Joseph's Hospital
RHINELANDER: Thursday, November 8, St. Mary's Hospital
RICE LAKE: Thursday, November 15, Lakeside Methodist Hospital

Instruction By RICHARD H. WASSERBURGER, M.D.

Chief of Cardiology, Veterans Administration Hospital, Madison, Associate Clinical Professor of Medicine, University of Wisconsin Medical School

9:30 a.m. INTRODUCTION: Genesis of the normal electrocardiogram; Analysis of the Bipolar system (standard limb leads) and the Unipolar system; Definition of normalcy.

10:30 a.m. COFFEE BREAK

10:45 a.m. CARDIAC ARRHYTHMIAS

11:30 a.m. COMMON ELECTROCARDIOGRAPHIC ABNORMALITIES: Left ventricular hypertrophy; Digitalis effect; Bundle Branch Block.

12:15 p.m. LUNCH (Each registrant pays $2.00, which includes lunch and cost of coffee breaks . . . NO REGISTRATION FEE.) Each registrant expected to eat lunch with group.

1:00 p.m. ELECTROCARDIOGRAPHIC CHANGES WITH: Pulmonary emphysema, anxiety, mitral stenosis, pulmonary emboli, and electrolyte imbalance.

1:30 p.m. CORONARY ARTERY DISEASE: Coronary insufficiency, and exercise tolerance tests.

2:30 p.m. COFFEE BREAK

2:45 p.m. MYOCARDIAL INFARCTION: Pericarditis and myocarditis.

A.A.G.P. CREDITS: 5 HOURS OF CATEGORY I.

LIMITED ATTENDANCE: Only 25 per meeting. Please do not register unless you really plan to attend! Registrations on "first come, first served basis".

COOPERATING SPONSORS: Wisconsin Heart Assn., Wisconsin Academy of General Practice, Wisconsin State Board of Health, and the Teaching Program of Merck Sharp & Dohme Postgraduate Program.

Wisconsin Hospital Association
Wisconsin Society Hospital Pharmacists

Dr. George F. Archambault, Chief of the Pharmacy Branch, Division of Hospitals, and Pharmacy Liaison Officer to the Office of the Surgeon General, U. S. Public Health Service, Washington, D. C., and president of the American Pharmaceutical Association, will be one of the featured speakers at the Hospital Pharmacist-Hospital Administrator Conference to be held at the University of Wisconsin October 19 and 20.

Doctor Archambault will speak on "The Use of Investigational Drugs" at the banquet Friday evening, October 19, at the Madison Club. Advance reservation by October 17 is necessary, and may be made with Richard S. Strommen, assistant professor, Extension Services in Pharmacy, 188 Pharmacy Building, University of Wisconsin, Madison 6. The cost is $4.00.

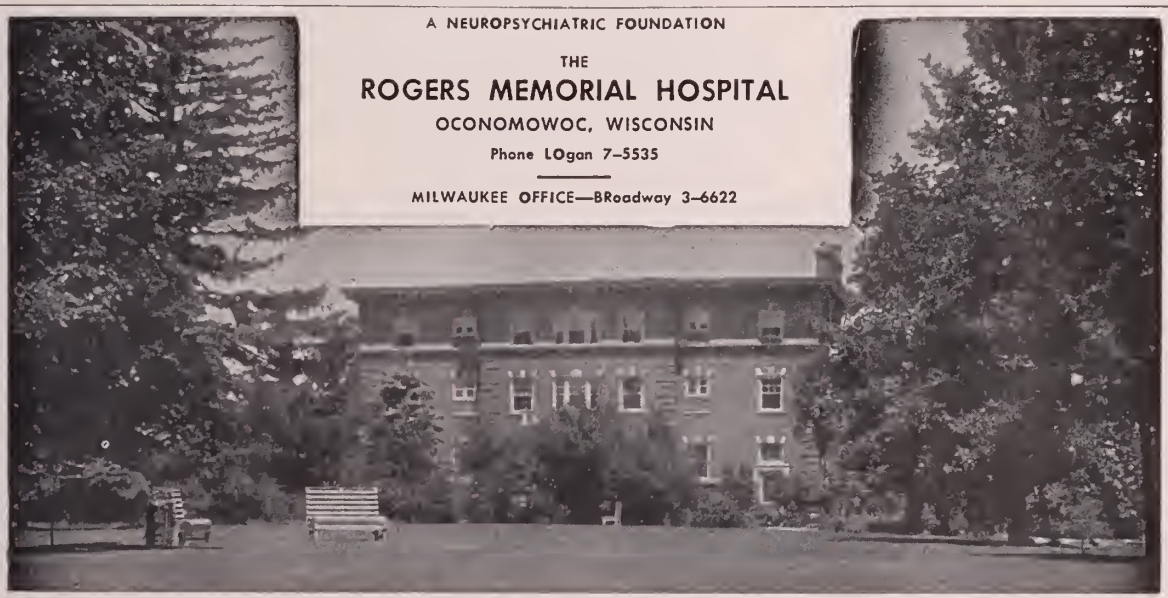
Daytime meetings on Friday will take place in the Wisconsin Center and will include talks by Hiram Sibley, director, Division of Hospital Community Resources, American Hospital Association, Chicago; James W. Allaben, assistant director, Pharmacy Services, University Hospitals, University of Wisconsin, Madison; Charles E. Welch, administrator, Memorial Community Hospital, Edgerton; Rheo V. Taylor, administrator, Vernon Memorial Hospital, Viroqua; Stanley W. Martin, executive director, Milwaukee Hospital, Milwaukee; Tom D. Rowe, dean, School of Pharmacy, University of Michigan, Ann Arbor; William M. Heller, Chief of Pharmacy Service, University Hospital, University of Arkansas, Little Rock; Edward J. Connors, superintendent, University Hospitals, Madison; Winston J. Durant, director, Pharmacy Services, University Hospitals, Madison; Robert J. Kubiak, R.Ph., staff pharmacist and purchasing agent, Mercy Hospital, Oshkosh; Sister Gladys, chief pharmacist, Milwaukee Hospital, Milwaukee; and Sister Marie de Carmel, chief pharmacist, St. Mary's Ringling Hospital, Baraboo.

Saturday's program includes an open house at the School of Pharmacy, tours of teaching and research facilities and of the pharmacy facilities at University Hospitals, and the Wisconsin vs. Iowa football game.

The Conference is jointly sponsored by the Wisconsin Hospital Association and the Wisconsin Society of Hospital Pharmacists in cooperation with Extension Services in Pharmacy of the University of Wisconsin.

Academy of Psychosomatic Medicine

The Academy of Psychosomatic Medicine will meet in Minneapolis November 1–3. The program has been oriented to the needs of practicing physicians. The patient, doctor, and family relationships will be emphasized. Write Bertram B. Moss, M.D., Executive Secretary, 55 E. Washington St., Chicago 2, Ill.



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Classified Advertisements

Advertisements in this section are accepted in two categories: PHYSICIANS' EXCHANGE and COMMERCIAL.

RATES: 10¢ per ward, with a minimum charge of $4.00 per ad. Additional insertions of same ad at one-half price each, maximum time one year. Display: $10.00 per column inch.

DEADLINE: Copy must be received by the 15th of the month preceding month of issue. Send copy to: Wisconsin Medical Journal, Box 1109, Madison 1, Wis.; or phone Alpine 6–3101.

PHYSICIANS' EXCHANGE: This section is limited to physicians and others desiring physicion plocement, sale of medical practice or equipment af o physician, sale or lease of medical buildings, etc. Advertisements from individual members of the State Medical Society of Wisconsin ore occepted without chorge. Widows of deceased member physicians are allowed to advertise without charge. The rates quoted above apply to ads ploced by clinics ond others. There is no additionol charge for ods with Dept. numbers. For these ads, oddress replies to: Dept. ___, 1% Wisconsin Medical Journal, Box 1109, Madison 1, Wis. Advertisers using Dept. numbers forbid the disclosure of their identity. All inquiries are forwarded to them immediotely.

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PHYSICIANS' EXCHANGE

WANTED TO RELOCATE: General practitioner in Wisconsin would like to relocate in a small town around 2,000 population in Wisconsin. Contact Dept. 983 in care of the Journal. m5tfn

POSITION WANTED: Board eligible general surgeon, 28 years old, interested in partnership or solo practice beginning July 1, 1963. Contact John E. Moenning, M.D., Marion County General Hospital, 10th and Locke Street, Indianapolis, Ind. 8–9

FOR SALE: UNOPPOSED small town general practice, southwestern Wisconsin. Modern, well equipped, air conditioned building, excellent open staff hospital nearby. Annual gross over $50,000. Contact Dept. 999 in care of the Journal. m8tfn

WANTED: ASSOCIATE IN GENERAL PRACTICE. Established practice in Minocqua resort area which is showing rapid growth, boasts good grammar schools and three-year-old million dollar high school, 20-bed hospital with open staff and nearly completed new addition which will double bed capacity. Own clinic building which consists of waiting room, business office, five examining rooms, laboratory. Salary for first year $1,000 per month. Second year salary plus percentage of gross. Partnership at five years. Start now. Contact Dept. 997 in care of the Journal. m7tfn

FOR SALE: ACTIVE GENERAL PRACTICE; Chicago's best area, considerable obstetrics and surgery, fully equipped, two nurses, annual gross $65,000 to $75,000, hospital association, will introduce. Contact Dept. 998 in care of the Journal. 7–9

WANTED: MEDICAL DIRECTOR for institution for the retarded. Specialty in pediatrics or internal medicine required. Staff of five physicians plus consultants in all specialties. Salary $18,672 to $21,672 depending on qualifications. Write: Mr. John M. Garstecki, Superintendent, Southern Colony and Training School, Union Grove, Wisconsin. g8tfn

WANTED: GENERAL PRACTITIONER as associate. Immediately available opportunity to practice in well established group of two. Replacement for sudden loss of partner. Eventual partnership. 126 E. Main Street, Madison. AL 6–3171. m9tfn

POSITION WANTED: Physician awaiting residency desires full or part time work as assistant to general practitioner in the Milwaukee area. Contact Dept. 11 in care of the Journal. 9

WANTED: PEDIATRICIAN, board certified or eligible; recent graduate preferred, to join seven men of various specialties with established practice with view to full partnership after trial period. Contact Dept. 993 in care of the Journal. 6–9

URGENTLY NEEDED: General practitioner for association with three physicians, to start as soon as possible. Central Wisconsin city. Salary—the going rate—with $1,000 per month minimum, and partnership as soon as mutually desired. Contact Dept. 984 in care of the Journal. m5tfn

POSITION WANTED: RADIOLOGIST, Board eligible, University training in diagnosis and therapy, hospital and private practice experience, desires position with hospital or association. Contact Dept. 995 in care of the Journal. m7tfn

POSITION WANTED: RADIOLOGIST, certified, seeks position preferably in solo practice. Experienced, University-trained. Contact Dept. 979 in care of the Journal. 4tfn

FOR SALE: Birtcher ultrasound electrocardiogram. Aloetherm diathermy, Astral refrigerator and 15 MA Fischer portable x-ray including ancillary equipment. Owner called into armed forces and equipment stored at 116 Prais St., Stevens Point, Wis. Please write to Thomas J. Martens, M.D., 1172 Fifth Street, Monterey, Calif. m5tfn

WANTED: INTERNIST, Board certified, to join two established surgeons. Excellent office facilities. Opposite 300-bed hospital—200-bed added expansion in progress. Town of 15,000. Central Wisconsin. Guaranteed salary. Percentage and partnership early prospects. Contact Dept. 981 in care of the Journal. m4tfn

WANTED: GENERAL PRACTITIONER to associate with two young general practitioners in established three-man clinic, located in west central Wisconsin. Excellent new facilities built to handle growing practice. Hospital and recreational facilities excellent. Early partnership for right man. Contact Dept. 996 in care of the Journal. m7tfn

WANTED: PEDIATRICIAN for newly organized group in Fox River Valley of Wisconsin. One other pediatrician in community of 45,000. Excellent living conditions, noted recreational area and above average opportunity. Salary two years, then partnership. Contact Dept. 6 in care of the Journal. m9tfn

the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 61, No. 10—OCTOBER 1962

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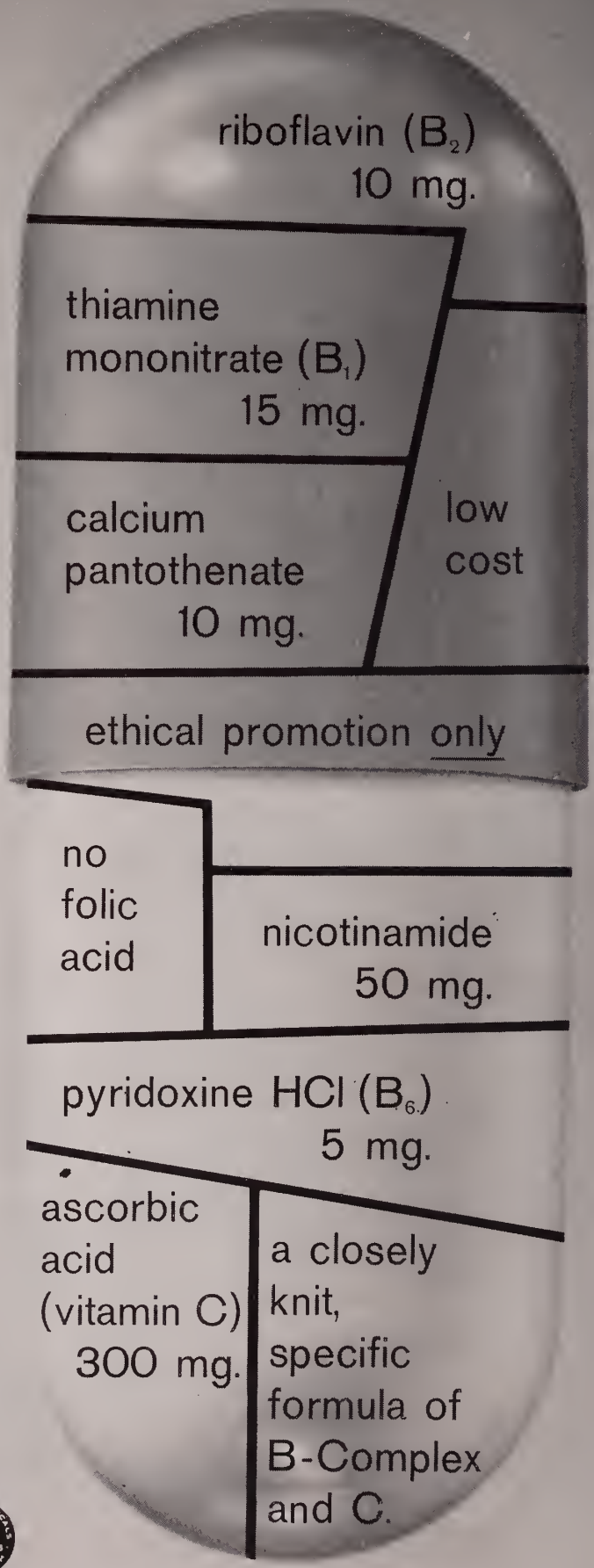

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Letters of Interest

PHARMACEUTICAL SUPPORT

TO DOCTOR HILL:

We have read of your interest in the development of oral polio vaccine programs by county medical societies.

We want you to know that this association and its members stand ready to be of assistance in this exemplary public health program.

In similar programs in other areas of the country, pharmacists have volunteered their services in the preparation of dosage units and in storage and have served as a medium for disseminating information concerning the program to the general public and urging participation in it.

Will you please let us know how we can be of assistance to you in this program.

Wisconsin Pharmaceutical Association
ALLEN DANIELS, R. Ph.,
Secretary

A THANK YOU

TO WMJ:

On behalf of our Maternal Mortality Study Committee, I wish to thank you and your Editorial Board for the use of material from our Maternal Mortality Survey in the July issue of the Journal.

The use of this material as a featured portion of the Journal lends great encouragement to those of us who have been actively identified with the Study for the past seven years.

T. A. LEONARD, M. D.
Chairman, Maternal Mortality Survey
Division on Maternal and Child Health
of the Commission on State Departments
State Medical Society of Wisconsin

CLINICAL PEDIATRICS

TO SMS:

Starting with the October issue, *Archives of Pediatrics* will be merged with two other distinguished journals—*American Practitioner* and *Quarterly Review of Pediatrics.*

The new journal will be called *CLINICAL PEDIATRICS* . . . will be a clinically centered journal rather than basically research-oriented as are other journals in the field . . . Its aim will be to keep you informed of the most recent advances in pediatrics, particularly those pertinent to office practice: allergy, communicable diseases, behavior problems, dermatology, newborn disorders, and care of the more common illnesses, to name a few. Emphasis will be on etiology, clinical observations, differential diagnoses, treatment and prognosis.

The editor will be Irving J. Wolman, Chairman of the Department of Pediatrics, Graduate School of Medicine, University of Pennsylvania; and Director of Clinical Laboratories and Hematologist of the Children's Hospital of Philadelphia.

WALTER KAHOE
Publisher
J. B. Lippincott Company

CIGARETTE SMOKING

TO SMS:

The Committee on Cancer of the American College of Chest Physicians for a number of years has been studying the effect of cigarette smoking on the pulmonary and cardiovascular systems. The members of the Board of Regents of the College are convinced that sufficient evidence has been accumulated to warrant issuing an official statement with regard to cigarette smoking and health. Accordingly, a resolution connecting cigarette smoking with various pulmonary and cardiovascular conditions was approved by the Board and issued by the College.

The resolution stated that the weight of scientific evidence distinctly indicates that cigarette smoking and the inhalation of other atmospheric pollutants have an association relationship which strongly suggests a causal connection with chronic bronchitis, pulmonary emphysema, cor pulmonale, cardiovascular diseases and cancer of the lung.

The College in its official statement urged its members and the medical profession in general to intensify their educational campaign directed toward the public, and the youth in particular, relative to the hazards of smoking.

The College urges that efforts to control atmospheric pollution be encouraged and that support be given to endeavors in the field of research for additional scientific information concerning other etiologic agents.

The resolution was introduced by Dr. J. Winthrop Peabody, Jr., Washington, D. C., to the House of Delegates of the American Medical Association and was referred to their Council on Drugs which is conducting a study on the relationship between tobacco and disease. A preliminary report is to be presented by the Council within 12 to 18 months. Surgeon General Luther L. Terry of the U. S. Public Health Service has announced plans for an advisory committee to make recommendations on the health aspects of smoking. The College resolution will be referred to this committee.

WARD BENTLEY
Director, Public Relations
American College of Chest Physicians

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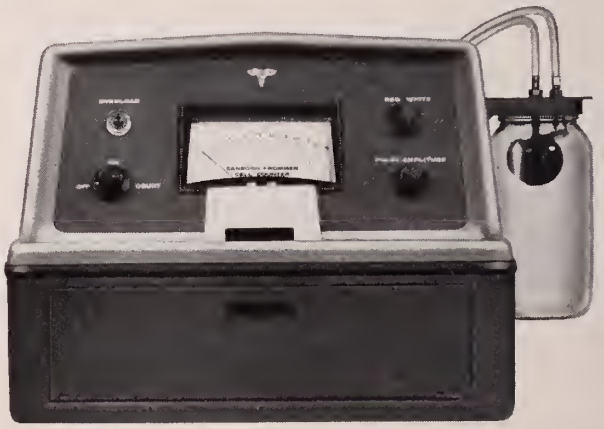

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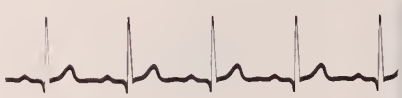

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County Society Proceedings

DANE

The Dane County Medical Society began its fall meeting schedule with the annual golf tournament at Blackhawk Country Club in Madison September 18. The nominating committee appointed to present a slate of officers for the coming year includes: *Drs. R. N. Allin*, chairman, *J. J. Mueller, G. G. Kring, F. D. Bernard* and *H. A. Peters.*

GRANT

The August meeting of the Grant County Medical Society was held at the home of *Dr. H. W. Carey*, Lancaster. *Dr. Robin N. Allin*, Madison, spoke on "Acute Cardiac Emergencies in General Practice." He also discussed "Political Medicine." An oral polio immunization program was discussed.

GREEN

The Green County Medical Society met at St. Clare Hospital, Monroe, on August 20 to discuss plans for countywide polio clinics. On September 18, the Society sponsored a golf day at the Monroe Country Club for the physicians, dentists and veterinarians of Green County.

JEFFERSON

Dr. William V. Luetke, Madison, spoke to members of the Jefferson County Medical Society at the Meadow Springs Country Club at Jefferson in September. Doctor Luetke, who is clinical professor of obstetrics and gynecology at the University of Wisconsin Medical School, talked on "Management of Abnormal Uterine Bleeding." His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the State Board of Health.

MILWAUKEE

The Medical Society of Milwaukee County is cooperating with the Milwaukee Academy of General Practice, Milwaukee County Hospital, Veterans Administration Center, Wood, Milwaukee Children's Hospital, Marquette University School of Medicine and the Milwaukee Pediatric Society in sponsoring the second annual Milwaukee Medical Conference November 14 and 15 at the Milwaukee County Hospital. (Details of the program appear elsewhere in this issue.)

Two new Medical Explorer Posts are being organized in Milwaukee this fall with the cooperation of The Medical Society of Milwaukee County. The medical explorer program, which is open to all boys of high school age, is one of eight in different areas of interest offered under the auspices of the Milwaukee County Boy Scouts of America.

Drs. Roman E. Galasinski and *George Murphy* are assisting in the establishment of a Southeast area post. The Southwest post will be advised by *Drs. DeLore Williams, Allen J. Savitt, Eugene Collins* and *James Francis Zimmer.*

Dr. Richard Mossey will serve as the Medical Society institutional representative to the Milwaukee medical program.

PIERCE–ST. CROIX

State Sen. Warren Knowles of New Richmond was the speaker at the August 21 meeting of the Pierce–St. Croix County Medical Society at New Richmond. The Society also met at New Richmond on September 25.

PRICE–TAYLOR

Dr. John Morledge, Madison, talked on "Hospital, Convalescent, and Rehabilitory Management in Myocardial Infarction" at the August meeting of the Price–Taylor County Medical Society at Medford. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Merck Sharp & Dohme Postgraduate Program.

RACINE

One of the nation's outstanding medical research specialists, Dr. Irvine H. Page, Cleveland, Ohio, lectured before the Racine County Medical Society September 20. Doctor Page is director of research at the Cleveland Clinic Foundation. He is author of eight books, dealing principally with the chemistry of the brain and nervous system, high blood pressure, and hardening of the arteries. His most recent volume, STROKES, was published in 1961.

Doctor Page is editor-in-chief of MODERN MEDICINE and serves on the editorial boards of five other publications in medicine, biology and physiology. He is past president of the American Heart Association and the American Society for the Study of Arteriosclerosis, former vice-president of the American Association for the Advancement of Science, member of the World Health Organization's Expert Advisory Board, and formerly served on the United States Public Health Service National Advisory Heart Council.

Physicians whose names appear in italic are members of the State Medical Society.

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COUNTY SOCIETY PROCEEDINGS *continued*

SAUK

The Sauk County Medical Society discussed the county health program at its September 11 meeting at Baraboo.

TREMPEALEAU–JACKSON–BUFFALO

Dr. George McAfee, Eau Claire dermatologist, spoke at the Tri-County Medical Society meeting held near Black River Falls in August. The September 25 meeting was held at Independence.

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Specialty Society Proceedings

Wisconsin Academy of General Practice

New officers of the Wisconsin Academy of General Practice were elected September 17 at the Academy's 14th annual meeting held in Milwaukee. They are:

President-elect—*Dr. Walton Menz*, Eau Claire
President—*Dr. Joseph S. Devitt*, Milwaukee
Secretary-treasurer—*Dr. John Kelble*, Milwaukee
Speaker—*Dr. Jack Brown*, Sparta
Vice-speaker—*Dr. Marvin Olson*, Wittenberg
Delegate—*Dr. Theodore Nereim*, Madison
Alternate delegate—*Dr. Charles Picard*, Superior
Directors—*Drs. Norbert Bauch*, Milwaukee; *Clifford Grand*, Ashland; and *James Weygandt*, Sheboygan Falls.

Wisconsin Society of Internal Medicine

The Wisconsin Society of Internal Medicine held its 1962 annual meeting and scientific program at Eau Claire September 14 and 15. Newly elected officers include:

President—*Dr. Warren K. Simmons*, Rhinelander
President-elect—*Dr. William L. Coffey, Jr.*, Milwaukee
Delegates to the American Society of Internal Medicine—*Dr. Robert L. Gilbert*, La Crosse, and Doctor Coffey.
Alternates—*Drs. George R. Barry*, Monroe, and *John H. Wishart*, Eau Claire.

August Derleth, noted Wisconsin historian and author from Sauk City, was the featured speaker during the banquet program.

Physicians whose names appear in italic are members of the State Medical Society.

Wisconsin Thoracic Society

The Wisconsin Thoracic Society held its fall meeting October 6 at the Veterans Administration Hospital at Madison. *Dr. Richard P. Jahn*, Milwaukee, president, presided.

Speakers for the day included *Drs. Raymond Evers*, Plymouth, superintendent and medical director, Rocky Knoll Sanatorium and Hospital; *Richard P. Jahn* and *Jack R. Hoffman*, Milwaukee, Muirdale Sanatorium and department of medicine, Marquette University School of Medicine; *R. H. Wasserburger* and R. J. Corliss, Madison cardiology section, Veterans Administration Hospital and department of medicine, University of Wisconsin Medical School; *F. Frank Zboralske* and Donald P. Schlueter, Milwaukee, departments of radiology and medicine, Milwaukee County General Hospital and Marquette University School of Medicine; David Y. Rosenzweig, Milwaukee, department of medicine, Milwaukee County General Hospital and Marquette University School of Medicine; Louis J. Kettel, Kermit Olson, Dimitri G. Catsaros, and David W. Cugell, Chicago, department of medicine, Veterans Administration Research Hospital, and Northwestern University Medical School; *William W. Stead*, Milwaukee, department of medicine, Milwaukee County General Hospital, Muirdale Sanatorium and Marquette University School of Medicine; and *Paul Hausmann*, Milwaukee, department of surgery, Marquette University School of Medicine.

Wiscansin internal medicine specialists took time off fram their twa-day scientific program to listen to Wisconsin's noted authar, August Derleth, Sauk City. Shawn in the picture, left ta right, are: Dr. *William L. Coffey, Jr.*, Milwaukee, president-elect af the Wiscansin Society of Internal Medicine; *Dr. Jahn H. Wishart*, Eau Cloire, council member; *Dr. Warren K. Simmans*, Rhinelander, president; Mr. Derleth; *Dr. Leslie G. Kindschi*, Manrae, immediate past president; and *Dr. Paul G. LaBissoniere*, Milwaukee, past president.

SPECIALTY PROCEEDINGS *continued*

Wisconsin Heart Association

Douglas County Unit

The Douglas County Heart Council has been replaced by the Douglas County Unit of the Wisconsin Heart Association. Former officers will continue in an official or advisory capacity, and the unit's primary purpose will be the education and promotion of the care and cure of heart diseases.

Future programing and education in Douglas County calls for training of county and local medical teams in the technique of closed chest cardiac massage as clinically developed at Johns Hopkins Medical School and the Massachusetts General Hospital. Trained local physicians will instruct nurses, policemen, firemen and industrial rescue squads in this technique.

Wisconsin Psychiatric Association

Northern Chapter

The Northern Chapter of the Wisconsin Psychiatric Association was host to the state group at its June meeting at Appleton. Newly elected officers of the Northern Chapter for the coming year are:

President—*Dr. Carl L. Kline*, Wausau
President-elect—*Dr. Albert A. Lorenz*, Eau Claire
Secretary—*Dr. William H. Heywood*, Marshfield
Treasurer—*Dr. John Petersik*, Oshkosh

American Board of Obstetrics and Gynecology

The next scheduled Part I (written) examination of the American Board of Obstetrics and Gynecology will be held at various examining centers in the United States, Canada, and military centers outside the continental United States on Friday, December 14.

Current bulletins may be obtained by writing to: Robert L. Faulkner, M. D., Executive Secretary and Treasurer, 2105 Adelbert Road, Cleveland 6, Ohio.

Diplomates of this Board are urged to notify the office of the Executive Secretary and Treasurer of a change in address.

Wisconsin Radiological Society

The 13th annual meeting of the Wisconsin Radiological Society was held September 14 to 16 at Maxwelton Braes, Bailey's Harbor.

Guest speakers were Dr. Howard B. Latourette, Iowa City, Ia., and Dr. Jerome F. Wiot, Cincinnati, Ohio. Doctor Latourette is professor of radiology at the University of Iowa Hospitals. He discussed the relationship of radioactive fallout to human milk consumption. Doctor Wiot, assistant professor of radiology at the University of Cincinnati Medical School, discussed unusual lesions of the gastrointestinal tract.

Other speakers were Drs. Arthur Fitz and Frank Yordy, Milwaukee, and G. H. Brister, Kelly H. Clifton, and *O. Arthur Steinnon*, Madison. *Dr. Robert G. Zach*, Monroe, presented a paper on the "Menace of Mechanical Quackery."

New officers elected are:

President—*Dr. Hobart H. Wright*, Milwaukee
President-elect—*Dr. Howard G. Bayley*, Beaver Dam
Vice-president—*Dr. Theodore J. Pfeffer*, Milwaukee
Secretary-treasurer—*Dr. Charles Benkendorf*, Green Bay
Directors—*Drs. Donald Babbitt* and *John Amberg*, Milwaukee
Board of Censors—*Dr. Morris Moel*, Milwaukee
Councilor to the American College of Radiology—*Dr. Robert Feulner*, Waukesha
Alternate—*Dr. Leslie Jones*, Racine

CORRECTION FOR PAGE 23—*Dr. L. G. Kindschi*, Monroe, is delegate to ASIM, instead of Dr. Gilbert.

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News of Wisconsin Physicians

To Occupy New Clinic Building

A contemporary clinic building, to be known as Medical Associates Building, is being constructed in Appleton for *Dr. William A. Dafoe.* The building will house, in addition to Doctor Dafoe, Dr. Gilbert Mueller, Jr.; *Dr. Blaine W. Claypool;* Dr. Darrell R. Slette, and Dr. Robert Davies, a dentist.

Swiss Surgeons Guests of Dr. Jackson

Twenty-six Swiss surgeons, 15 of their wives, and one daughter spent a three-day visit in Madison in September as guests of *Dr. Arnold S. Jackson* and Mrs. Jackson. All eminent leaders in their profession in Switzerland, France and Germany, the visiting surgeons are members of the International College of Surgeons.

It was at the installation of the chapter at Geneva, when Doctor Jackson spoke at the banquet, that they became interested in Wisconsin and its Swiss community at New Glarus. A reception by the mayor and citizens of New Glarus was part of the three-day program planned for the visitors. They also attended surgical clinics and medical programs and took tours of the State Capitol, University of Wisconsin and McArdle Cancer Research Institute in Madison.

Lakeland Elects Officers

Officers of the medical staff of Lakeland Hospital at Delavan recently elected *Dr. Joseph Schrock,* Sharon, chief of staff to succeed *Dr. George Truex,* Darien, who was elected to the executive committee.

Dr. W. C. Woods, Delavan, was elected vice-chief of staff, succeeding Doctor Schrock. *Dr. Henry Mol,* Elkhorn, was elected secretary–treasurer to succeed Doctor Woods.

New Clinic in Richland Center

Seven physicians have moved into the new Richland Medical Clinic, Ltd., in Richland Center. They are: *Drs. R. E. Housner, Robert G. Hansel, K. H. Meyer, George Parke, L. M. Pippin, Jack Spear* and *D. F. Taft.*

Dr. Hirschboeck Speaks at Jubilee

Dr. John S. Hirschboeck, Milwaukee, dean of Marquette University School of Medicine, spoke to about 150 physicians who were guests September 11 at a dinner commemorating the golden jubilee of St. Mary's Hospital in Madison.

Dr. Mallow Moves to Arizona

Dr. Harvey G. E. Mallow and his family have left Fort Atkinson for Phoenix, Ariz., where Doctor Mallow will practice medicine and surgery. Dr. James Sprecher, a native of Wisconsin and formerly house officer at St. Joseph's Hospital, South Bend, Ind., will take over Doctor Mallow's Fort Atkinson practice.

Dr. Conway Reelected

Dr. James P. Conway, Milwaukee, an ardent supporter of certified milk, recently was reelected president of the American Association of Medical Milk Commissions, Inc.

Dr. Hill to Practice in Eau Claire

Dr. E. F. Hill, who has recently completed a three-year residency in obstetrics and gynecology, will engage in the private practice of medicine in Eau Claire.

Physicians Serve Spring Valley

Dr. D. A. Crippin, surgeon, and *Dr. S. R. Lee,* both of the Red Cedar Clinic in Menomonie, are part of a team of Menomonie physicians who are serving Spring Valley on a part-time basis.

Dr. Jackson on Program Committee

Dr. Arnold S. Jackson, director of the Jackson Clinic at Madison, served as co-chairman of the scientific program committee for the International Congress of the International College of Surgeons in New York City September 9 to 13.

Doctor Jackson was made an honorary fellow of the International College of Surgeons in 1959. He was chosen as one of 11 distinguished surgeons in the world to receive the honor because of their contribution to surgicial progress.

Dr. Thomas Observes 86th Birthday

Dr. William O. Thomas, Clinton, celebrated his 86th birthday anniversary this summer with 100 relatives and friends from Clinton and nearby communities. Doctor Thomas, who is recovering from a hip fracture sustained about a year ago, is at his office afternoons.

Kansas Symposium Includes Dr. Evans

Dr. Alfred S. Evans, Madison, was one of six clinicians in the infectious disease field who participated in a medical symposium held September 14 at the University of Kansas Medical Center's Battenfeld Auditorium in Kansas City, Kansas. The symposium was sponsored by the American Academy of General Practice and the University of Kansas School of Medicine.

Physicians whose names appear in italic are members of the State Medical Society.

WISCONSIN PHYSICIANS *continued*

Dr. Kelly Joins Rice Clinic

Dr. Joseph Kelly, who has just completed two years at Ford Ord, Calif., where he served as captain in the Army Medical Corps, has joined the staff of the Rice Clinic at Stevens Point as a specialist in internal medicine.

A native of Fair Haven, Vt., Doctor Kelly was graduated from the University of Vermont Medical School in 1956. He interned at University Hospitals, Madison, from 1956 to 1957 and spent the next three years there as a resident intern in internal medicine. In his third year he was named chief medical resident.

Dr. Barr Attends Conference in England

Dr. Arnold H. Barr, Port Washington, attended the Third International Conference on Alcohol and Road Traffic, sponsored by the British Medical Association, at Tavistock Square, London, England, September 3–7.

Dr. Hofmeister Speaks in Chicago

Dr. Frederick J. Hofmeister, Milwaukee, spoke on "The Nurses' Conferences" at the third annual Conference on Obstetric, Gynecologic and Neonatal Nursing held September 13 to 15 in Chicago. The meeting was sponsored by District VI of the American College of Obstetricians and Gynecologists and Doctor Hofmeister is chairman of the Committee on Conferences on Obstetric, Gynecologic and Neonatal Nursing.

Kenosha Cancer Unit Elects Physicians

Dr. Stephen Holt, Kenosha, has been elected president of the Kenosha unit of the American Cancer Society. Elected board members include *Drs. V. N. Miller, Harry Schwartz, David Milliken* and *Louis Olsman*.

Dr. Beckfield Joins Eau Claire Hospital Staff

Dr. William J. Beckfield has joined the staff of Luther Hospital in Eau Claire as a pathologist and will be working with *Dr. Willard Aronson*, pathologist.

Doctor Beckfield formerly was at Philadelphia General Hospital where he was chief and director of surgical pathology, and associate professor in the Graduate School of Medicine at the University of Pennsylvania. He took his undergraduate work at Allegheny College and received his M. D. degree from the University of Pennsylvania.

Doctor Beckfield is the author of more than 20 articles. He is a member of the American Association of Pathologists and Bacteriologists and the American Society of Experimental Pathology. He is a diplomate of the American Board of Pathology.

Racine Physicians Open New Offices

Ten Racine physicians have opened their offices in a new medical building which is the first of its type in the Racine area. The building is not being operated as a clinic. With the exception of a single two-man partnership, the physicians practice independently. Each physician has his own suite, including a waiting room.

The 10 physicians are: *Drs. Earnest MacVicar, W. H. Williamson, J. A. McHale, Edward P. Lauerman, James Holman, Frank Hilpert, Arthur Jacobsen, William Henken, C. W. Christenson* and *K. W. Covell.*

Dr. Harkness Practices in Philippines

Dr. John W. Harkness, Wauwatosa, his wife and their five children are now in Manila, P. I., where Doctor Harkness, who is employed by the U. S. Public Health Service, is primarily responsible for the health of Peace Corps personnel in the Philippines.

Dr. Oberfeld Addresses Kiwanians

Dr. Harold H. Oberfeld, South Milwaukee, recently addressed the Kiwanis Club of South Milwaukee on recent medical developments. Doctor Oberfeld is a former president of the club.

Dr. Jacobson Speaks on Health Problems

Dr. L. L. Jacobson, Eagle River, talked on "Health Problems Produced by Obesity" at a recent meeting of the Eagle River Hospital Auxiliary.

Dr. Stengel Receives Award

A special award for the outstanding resident teacher was given to *Dr. Bruce F. Stengel*, Wood, upon completion of four years of specialty training in general surgery at the Veterans Administration Hospital at Wood. The award is given annually on the decision of the junior and senior medical students at the Marquette University School of Medicine.

Doctor Stengel recently presented scientific papers at the National Senior Residents' conference at Oklahoma City, Okla., the Wisconsin State Surgical Society meeting in Milwaukee, and the Annual Clinical Day at the Veterans Administration Hospital at Wood. He is assistant chief of surgery at the Wood VA hospital.

Dr. Gungor Begins Practice at Loyal

Dr. Bahri O. Gungor, formerly of Vienna, Va., is the first resident doctor in the new Loyal Clinic in Clark County. Doctor Gungor received his M. D. degree in 1952 from the Medical Faculty of Istanbul, Turkey, and came to the United States in 1953.

Doctor Gungor was employed at Four Rivers General Hospital at Four Rivers, Mass., until 1955 and completed his internship and residency at Lincoln Hospital in New York where he remained until 1957. He then became affiliated with the Dover General Hospital in New Jersey and was a staff

Facts about

WISCONSIN PHYSICIANS SERVICE

PREPARED BY THE COMMISSION ON MEDICAL CARE PLANS

LEGAL ALERT!

The Tennessee Court of Appeals has just decided a case involving Blue Shield that physicians will find to be most interesting.

The facts: A Miss Joyce Fee, a paralytic, was a patient of Doctor Strang et al for several years, without cost to her. As part of a rehabilitation program, the doctors gave her a job as mail clerk handling the mailing of statements, etc. for all doctors in the building occupied by Doctors Strang and Shobe. The physicians trusted her implicitly.

Over an extended period, she asked them to sign Blue Shield claim forms in blank, which they did. She then filled in her name as payee, and listed non-existent operations. By this technique she collected over two thousand dollars from Tennessee Blue Shield.

When the fraud was ultimately discovered, Blue Shield sued the doctors to recover all amounts paid. The trial judge decided that both the Plan and the physicians were innocent victims, and left the burden remain where it was, viz. on the Plan.

The court of appeals reversed, admitting that the circumstances created strong sympathy for the physicians, but that as a matter of law where two innocent parties are defrauded the loss must fall on the innocent party whose negligence made the fraud possible. The court said that the physicians, while trusting her, were nevertheless negligent in signing claim forms in blank. The court said:

> "Defendants Shobe and Strang knew that complainant required a physician's certificate in support of claims made against it and must have known that a certificate signed by them would almost certainly be paid. In signing certificates in blank or without checking them to see whether they had performed an operation on the claimant they were guilty of a serious breach of duty to complainant amounting in equity to a constructive fraud. It is of no consequence to complainant whether defendants acted willfully or through ignorance resulting from negligence."

Howard Hassard, General Counsel, *Legal Service Bulletin* of National Assaciation of Blue Shield Plans, Chicogo, August 10, 1962.

THE DOCTORS' PLAN OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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physician at Lynchburg Training School. In 1960 he and his family moved to Vienna where he maintained a private practice and also practiced at DeWitt Army Hospital at Fort Belvoir, Va., and at the Medical Dispensary at Fort Meyer.

Dr. Gallagher Goes to Peru

Dr. William B. Gallagher, La Crosse, has spent the past two months in Trujillo, Peru, as a member of Project Hope. He has been a volunteer in a program set up in 1959 by Dr. William Walsh, Washington, D. C. It is a nongovernmental nonprofit organization bringing aid to less developed countries and the work is being carried out on the ship Hope, formerly the USS Consolation, a Navy hospital ship released by the Navy from its mothball fleet for the project. Doctor Gallagher is a member of the St. Francis Hospital medical staff and of the Skemp Clinic in La Crosse.

Dr. Schuster Opens Madison Office

Dr. Donald S. Schuster has opened an office for the practice of dermatology at Madison. He also will serve as clinical instructor in dermatology at the University Hospitals.

D. S. Schuster, M.D.

Formerly an instructor at Stanford University Medical School and chief of the section of dermatology at Veterans Administration Hospital, Palo Alto, Calif., Doctor Schuster lived in Madison while he was earning his B.A. and M.D. degrees at the University of Wisconsin and during his first year of residency at University Hospitals. He interned at Ohio State University Hospital and took his second and third years of residency at the University of Michigan Hospital.

From 1953 to 1955, Doctor Schuster was a captain in the U. S. Air Force. He is a member of the American Academy of Dermatology, the Society of Investigative Dermatology, and the Pacific Dermatological Association.

Dr. Hable Resumes Practice at Loyal

Dr. A. P. Hable has resumed his medical practice in Loyal.

Dr. Allin Speaks at Edgerton

Dr. Robin N. Allin, Madison, who is serving as chairman of the Wisconsin Professional Political Action Committee, spoke on "Medical Care of the Aged" at a meeting of the City Federation of Women's Clubs at Edgerton September 24.

Dr. Braun Speaks to Optimists

Dr. N. Peter Braun, Sheboygan, who was born in South Africa, recently spoke to the Sheboygan Optimist Club on his trip to Cape Town, South Africa. He showed colored slides and commented on the political aspects of the new African states.

Dr. Ellison Named County Surgery Chief

Dr. Edwin H. Ellison, Milwaukee, has been appointed director of the department of surgery at Milwaukee County General Hospital. A graduate of Ohio State University, Doctor Ellison is a professor and chairman of the department of surgery at Marquette University School of Medicine.

Dr. Morton on Algerian Mission

Dr. S. A. Morton, Milwaukee, clinical professor of radiology at Marquette university and senior radiologist at Columbia hospital, spent September working in a 1,200 bed Algerian hospital. He was one of eight physicians who are being sent as an emergency team to Algiers by MEDICO, a service of CARE, at the request of the provisional Algerian government to care for victims of the recent conflict in that country.

Medford Women Hear Dr. Keuer

Members of the Medford Business and Professional Women's Club heard *Dr. James Keuer,* Medford, talk on the "History of Surgery" at their September meeting.

Dr. Mallin Is New Medical Director

Dr. Sanford R. Mallin, Milwaukee, has been appointed medical director of the Milwaukee Jewish Convalescent Hospital. He maintains an office in Milwaukee where he specializes in internal medicine and metabolic and endocrine diseases.

Doctor Mallin received his M. D. degree from the University of Wisconsin in 1957. He interned at Mount Sinai Hospital, Milwaukee, and served as a resident in internal medicine at the Hahnemann Hospital and Medical College, Philadelphia, Pa.

During the past two years he completed a fellowship in the department of metabolic and endocrine research at the Michael Reese Hospital in Chicago and was appointed as a clinical trainee of the National Institutes of Health. Many of his manuscripts have been published in medical journals. He also was an instructor in medicine at the Chicago Medical School.

Attends Cancer Congress in Russia

Dr. Norman O. Becker, Fond du Lac, attended the International Congress on Cancer held in Moscow this summer. Doctor Becker and Mrs. Becker also toured Egypt, Lebanon, Germany, Greece, Turkey, France and Italy. The real paradox of the trip, Doctor Becker reported, was the extreme friendliness of the Soviet people contrasted with the anti-United States feeling in official government circles.

Dr. Schmitt Moves to Indiana

Dr. R. W. Schmitt, who began his medical practice in Phelps in 1946 after finishing two years as an Army captain, has assumed the post of medical director and consulting psychiatrist for the Child Clinic of Wayne County, Inc., Richmond, Ind. He had been practicing in Topeka, Kan.

Dr. Krohn Attends Convention

Dr. Robert Krohn, chief of staff of the Krohn Clinic and Hospital at Black River Falls, attended the annual convention of the International College of Surgeons in New York City in September. He also visited his son, Dr. Gene Krohn, stationed with the Air Force at Portsmouth, N. H. Dr. Gene Krohn was released from service October 13 and now is back as a member of the staff of the Krohn Clinic and Hospital.

Dr. Leering Comes to Reedsville

Dr. H. Leering, a native of Holland, has opened his medical practice in the new Medical Center at Reedsville. Doctor Leering received his doctorate in Europe and came to the United States four years ago. He has just completed his residency at Dunham Hospital in Cincinnati, Ohio.

Dr. Wood to Practice in Iola

Dr. Charles F. Wood, British-born physician who formerly practiced in Morris, N. Y., has set up his medical practice in Iola. The Waupaca County village with a population of 831 had been searching for a physician since it lost both of its physicians last spring.

Doctor Wood is a graduate of Leeds Medical College in London. A general practitioner with experience in obstetrics and surgery and special training in anesthesia, he emigrated from England to Canada and practiced in western Manitoba until moving to New York State a year ago.

Dr. Lepley Speaks to Marion Rotarians

Dr. Derward Lepley, Milwaukee, spoke to the Marion Rotary Club recently on the progress made in heart surgery since the mid 1950's when the first intracardiac surgery was performed.

Dr. Bowers at Clark Air Base

United States Air Force hospital officials and interns at Clark Air Base in the Philippines recently heard *Dr. John Z. Bowers,* former dean of the University of Wisconsin Medical School, speak on the internship and residency training program in the Philippines. Doctor Bowers is spending a year in the Far East to study medical schools under a travel fellowship of the China Medical Board of the Rockefeller Foundation.

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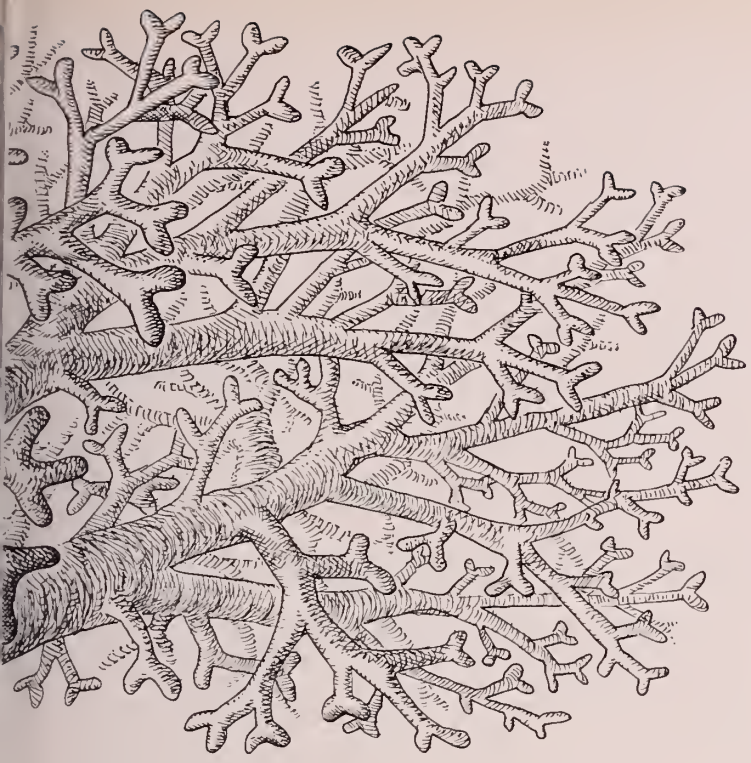

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WISCONSIN PHYSICIANS *continued*

Dr. Charles Smith Joins Group

Dr. Charles C. Smith, has become associated with *Drs. Victor F. Neu, Richard H. Troup* and *Kenneth A. Forbes* in the practice of urology and urologic surgery at Green Bay. A native of Green Bay, Doctor Smith received his medical training at Northwestern University Medical School. Following internship he was a surgical resident at St. Luke's Hospital in Chicago for one year. After spending two years as a surgeon in the United States Air Force, he was at the Veterans Administration Hospital at Hines, Ill., for three years of special urologic training.

Dr. Ris Receives Grant

A Public Health Service grant of $23,288 for a one-year period has been awarded to Dr. Hans Ris, University Hospitals, for a research project entitled "Submicroscopic Organization of Chromosomes." The grant also has a commitment for three additional years in amounts of $23,500, $24,000 and $24,500.

The Closed Chest Method of Cardiopulmonary Resuscitation: Benefits and Hazards

In view of the growing interest in the closed chest method of cardiopulmonary resuscitation, and the possible dangers in its indiscriminate use, the following statement has been prepared as a guide to the public regarding the present place of this new technique.

The closed chest method of cardiopulmonary resuscitation has been proved effective as a medical procedure in certain cases of stoppage or disruption of the heart beat. However, it is to be considered a temporary method and additional medical treatment, which may include the use of drugs and an electric defibrillator, is usually required to restore the circulation permanently.

The heart beat may stop as a result of a variety of conditions or circumstances such as water submersion, electrical shock, asphyxiation, heart attack, or during anesthesia or surgery. Most people who experience sudden stoppage or disruption of the heart beat (cardiac arrest) cannot be saved even under ideal circumstances in a hospital. The least measure of success has been experienced in coronary heart "attack" cases. However, the prompt use of cardiopulmonary resuscitation has enabled lives to be saved which previously might have been lost. The new technique of closed chest cardiac massage makes it possible to continue blood circulation without opening the chest, thus greatly extending the possibilities for attempting saving of life. Consequently, it is the desire of all concerned to achieve widespread use of this method where it can be used safely and effectively.

The public should be advised, however, that the application of closed chest cardiopulmonary resuscitation calls for a working diagnosis of the victim's condition. It is important to be sure that the circulation has actually stopped because the method involves certain hazards. Reported injuries to patients have included damage to the heart and liver, internal bleeding, multiple rib fractures, and puncture of the lungs. In untrained hands the risk of injury is increased. It is particularly important to avoid the possibility of inflicting serious injury on a person under the mistaken impression that cardiac arrest has occurred when the individual has simply fainted or lost consciousness from some other cause.

Successful application of closed chest cardiopulmonary resuscitation depends on thorough and careful training. One is most unlikely to be able to achieve artificial blood circulation by this method if his only training is from reading written instructions.

In view of these facts, it is suggested that closed chest cardiopulmonary resuscitation be applied only by carefully trained personnel so that it may be utilized with the greatest safety and effectiveness. Two qualified persons are preferable because it is necessary to maintain artificial respiration at the same time the heart is being massaged externally. A decision as to whether training in this procedure should be extended to certain segments of the general public must be postponed until further experience accumulates.

The undersigned organizations joining in this statement believe that emphasis should be placed at this time on training physicians, dentists, nurses and specially qualified emergency rescue personnel so that the procedure will become more widely available.

American Heart Association, Inc.
American National Red Cross
Industrial Medical Association

From an editorial in *Circulation*, Vol. XXVI, No. 3, September, 1962; also printed in the *Journal of Occupational Medicine*, September, 1962, Vol. 4, No. 9.

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1. Stevenson, L.E.: M. Ann. District of Columbia *30*:409 (July) 1961.

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Prescribing information adopted Jan. 1961

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WISCONSIN PHYSICIANS *continued*

Dr. Kempthorne Begins Practice

Dr. Gerald C. Kempthorne, a native of Dodgeville, has opened his office for the practice of medicine and surgery in the new Spring Green medical building sponsored by the Spring Green Lions Club. Doctor Kempthorne received a B. S. degree from the University of Wisconsin, M. Sc. degree from the Kansas State University, and M. D. degree from the University of Maryland School of Medicine and College of Physicians and Surgeons. He recently completed an internship at Cook County Hospital in Chicago, and he has been designated as a diplomate of the National Board of Medical Examiners. Doctor Kempthorne served four years in the U. S. Navy as a hospital corpsman during the Korean conflict.

Dr. Leicht Opens Green Bay Office

Dr. Thomas R. Leicht, who received his residency training at University Hospitals, Madison, from 1959 to 1962, has opened his office in Green Bay and will specialize in internal medicine and cardiology. He has spent the past year as a research fellow in

BIRTH DEFECTS CLINICAL STUDY CENTER
at the University of Wisconsin Medical Center

A child is born—deformed. Why? The newly established Birth Defects Clinical Study Center at the University of Wisconsin Medical Center is trying to find out.

Under direction of Dr. David W. Smith, assistant professor of pediatrics, the center's associates are searching for causes of congenital abnormalities, or birth defects, in the hope of someday preventing them.

"Our studies should help us advise the parents of some affected children," Doctor Smith believes. All too often, the birth of a malformed child results in psychologically disturbed parents who fear they were responsible for the child's defects. Many such parents needlessly refrain from having more children, for some congenital abnormalities are not inherited, the director explains.

Since the possible causes of birth defects touch so many different areas, scientists from several UW departments contribute to the center's research. The clinical phase of the program is supported by a recent $6,408 grant from the National Foundation–March of Dimes.

Which subjects to study and how to study them is Doctor Smith's main problem. He looks for similar patterns of abnormalities among deformed babies at the University Children's Hospital, state institutions for the mentally retarded, and the Pediatrics Outpatient Clinic.

"Similar defect patterns," Doctor Smith states, "may reflect similar causes." Through further tests and studies, an accurate diagnosis may be made and parental counseling given, he continues.

One such study involves the chromosome patterns found in the child. Dr. Stanley Inhorn, assistant director of the State Laboratory of Hygiene, prepares cell cultures for chromosome studies done by Prof. Klaus Patau and Eeva Therman, of the medical genetics and pathology departments.

A few birth defects are now known to be associated with abnormal chromosome patterns, such as the presence of an extra chromosome or fusion of a part of one chromosome onto another. Recently, the UW research group discovered that two types of abnormalities involving multiple physical defects result from the presence of an extra chromosome (making 47 instead of the normal 46 chromosomes found in human cells).

What can be learned from the tissues of affected children? Dr. Robert DeMars, assistant professor of medical genetics, examines tissue cultures for chemical mistakes. Pediatrics professor, Dr. Harry A. Waisman, and his associates assist in biochemical studies of the patients themselves.

A study of minor abnormalities among newborn infants at St. Mary's Hospital, Madison, has been conducted by Dr. Philip Marden, intern at the University Children's Hospital.

When a baby is suspected of having an inherited defect, studies of his family tree, or pedigree, are made. Such studies as well as laboratory tests help Dr. John Opitz, of the pediatrics and medical genetics departments, and the other doctors give genetic counseling to the baby's parents.

A combination of these tests and clinical observations should lead to a better understanding of birth defects and possibly of their causes, Doctor Smith believes.

"At least," the director states, "if we can properly diagnose a given defect, we can predict the affected child's future development and treat him accordingly." He explains that some babies will die within a few months, anyway, so it is best to leave them alone. Others, however, may be able to lead relatively normal lives if they receive appropriate care as infants.

The Madison center is the fifth of its kind in the nation, aided by March of Dimes funds.

cardiovascular disease at University Hospitals, Madison. Doctor Leicht received his M. D. degree from the University of Wisconsin Medical School in 1958 and interned at Presbyterian Hospital Denver, Colo.

Dr. Slette Opens Appleton Office

Dr. Darrell R. Slette recently started his practice in internal medicine at Appleton. He is a graduate of the University of Wisconsin, where he was a premedical student, and of the George Washington Medical School, Washington, D. C.

Dr. Dockter Moves to Plum City

Dr. William Dockter, who has served Spring Valley for several years, has moved his office to Plum City.

Dr. Geppert Joins Dean Clinic

The Dean Clinic at Madison has announced the association of *Dr. Charles H. Geppert* who will specialize in the practice of pediatrics.

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WISCONSIN PHYSICIANS *continued*

Wisconsin Draws New Physicians

Several physicians who have been practicing out of state have recently moved to Wisconsin to set up their medical practice.

Dr. William A. Corcoran, a Michigan native, has joined the Walsh–Henkle Medical Group in Port Washington. He is a graduate of the University of Michigan Medical School.

Dr. Warne Ramsey, who was raised in Iowa and received his medical training at the State University of Iowa, has become associated with the Red Cedar Clinic at Menomonie.

Dr. Leo Nelson, formerly of Shafer, Minn., has joined the St. Croix Falls Clinic staff. He received his medical training at the University of Minnesota and interned at Bethesda Hospital in St. Paul, Minn.

Dr. O. S. Keiser, formerly of Muscatine, Ia., has established his medical practice in De Pere.

Dr. M. Mirhoseini has opened offices in Athens and has been accepted to the medical and surgical staffs at St. Mary's and Memorial Hospitals, Wausau. A native of Iran, Doctor Mirhoseini graduated from the University of Teheran, Iran, and interned at the University Hospital in Teheran in 1955.

He then came to the United States and after graduating with honors in medicine, surgery and obstetrics from the University of Cincinnati Hospital Jewish Center in 1959, he located in Winnipeg, Manitoba, Canada. He spent three years in residency in general medicine and surgery at Winnipeg General, VA, Children's and St. Boniface General Hospitals, and was also an instructor in medicine and surgery at the University of Manitoba. He was chief resident surgeon at St. Boniface General Hospital.

Physicians on Television Panel

Dr. Harold Hardman, chairman of the department of pharmacology of the Marquette School of Medicine, and *Dr. William W. Engstrom*, Milwaukee, participated in a panel discussion on "Testing New Drugs" on the Milwaukee Public Library's weekly television program.

UW Physicians Attend Meetings

Drs. Peter A. Duehr, Frederick J. Davis and *Matthew D. Davis*, University Hospitals, Madison, attended the Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology meeting at Bailey's Harbor September 21 through 23.

Dr. A. R. Curreri, University Hospitals, Madison, attended the Surgical Lung Adjuvant Program meeting in Boston September 21 and a Cancer Council meeting in Washington, D. C., September 22 and 23.

Society Records

Membership Report as of August 31, 1962

NEW MEMBERS

Thomas P. Chisholm, Arcadia Medical Center, Arcadia.
Elias T. Eyvindsson, 119 North 2nd Avenue, Park Falls.
Harold F. Hardman, 561 North 15th Street, Milwaukee.
Thomas G. Haugh, 133 Main Street, Dousman.

CHANGES OF ADDRESS

Donald S. Ackerman, Cudahy, to 6800 North 76th Street, Milwaukee 23.
John R. Allen, to P. O. Box 3140, Madison.
Gerson C. Bernhard, to 425 East Wisconsin Avenue, Milwaukee.
Leo M. Boxer, to 3400 West Wisconsin Avenue, Milwaukee 8.
Sidney M. Boxer, to 3400 West Wisconsin Avenue, Milwaukee 8.
Frank J. Brown, to P. O. Box 276, Chippewa Falls.
J. O. Cales, Monroe, to 5644 South Harper, Chicago 37, Illinois.
Richard D. Carr, to 6821 Pageantry, Long Beach, California.
Charles W. Christenson, 500 Walton Avenue, Racine.
Christo Christoff, Madison, to 6589 North Johoma Avenue, Chicago, Illinois.
John E. Cordes, 5232 West Oklahoma Avenue, Milwaukee.
Elsa B. Edelman, 763 North 18th Street, Milwaukee 3.
Eugene H. Ephron, 4364 Cannington Drive, San Diego 17, California.
W. W. Fieber, Fond du Lac, to 2149 South 108th Street, West Allis.
C. J. Finn, 111 East Wisconsin Avenue, Milwaukee 2.
J. H. Flinn, Madison, to 841 Shoemaker Road, Webster, New York.
David J. Freeman, R. F. D. 5 Townline Road, Wausau.
James F. Guhl, 5232 West Oklahoma, Milwaukee 19.
Joseph Himes, 100 Indian Creek Court, Milwaukee 17.
John Hogan, Mercer, to Campbellsville, Kentucky.
Donald T. Hughson, Milwaukee, to 10425 West North Avenue, Brookfield.
Lloyd F. Jenk, Milwaukee, to 2500 North 108th Street, Wauwatosa 13.
Robert Karen, 3501 West Greenfield, Milwaukee.
Thomas J. Kozina, Milwaukee, to 3631 West Abbott, Greenfield.
Lawrence L. Larsen, Hales Corners, to 6520 North Atwohl Drive, Milwaukee 9.
H. G. E. Mallow, Fort Atkinson, to 2256 North 15th Avenue, Phoenix 7, Arizona.
J. E. McEnroe, Cross Plains, to 606 State Street, Petoskey, Michigan.
Elton Mendeloff, Milwaukee, to 10425 West North Avenue, Brookfield.
E. H. Mensing, 2204 West Rochelle, Milwaukee 9.
George P. Nichols, 424 East Longview Street, Appleton.
Ronald W. Olson, 16 East Gorham Street, Madison 3.
Andrew J. Owens, 4441 West Fond du Lac Avenue, Milwaukee.
*Robert L. Pettera, Rib Lake, to U. S. A. D. Det. 6006.01, Building #140, Fort Lewis, Washington.
L. T. Plouff, 1112 East Melrose, Appleton.
*Mac C. Roller, Whiteland, Indiana, to Hq. & Hq. Det. 25th Med. Bn., APO 25, San Francisco, California.
*Robert D. Schmidt, 821 Medical Group SAC, Ellsworth Air Force Base, South Dakota.
H. M. Stang, Hayward, to 340 Gilbert Avenue, Eau Claire.
Anna L. Standard, 1610 North 5th Street, Milwaukee.
G. O. Stubenrauch, West Allis, to 8182 Frelding Lane, Greendale.
R. C. Thompson, Cumberland, to St. Croix Falls.
Vernon G. Ward, Madison, to 5 West 31st Street, Kearney, Nebraska.
Joseph Weinstein, 4602 Packard Avenue, Milwaukee.
Thomas W. Weis, 403 North Grand Avenue, Waukesha.
S. H. Wetzler, 4109 North Downer Avenue, Milwaukee 11.

*Military member.

OBJECTIVES AND PROGRAM OF THE A.M.A. COMMITTEE ON NURSING

In an effort to protect and foster an enduring alliance of understanding and cooperation between medicine and nursing, the A.M.A. Committee on Nursing has instituted a continuing program of liaison, communication, education, and research. The Committee has authorized publication of a report on its objectives and program which appears in *The Journal of The American Medical Association*, 181:430 (Aug. 4) 1962.

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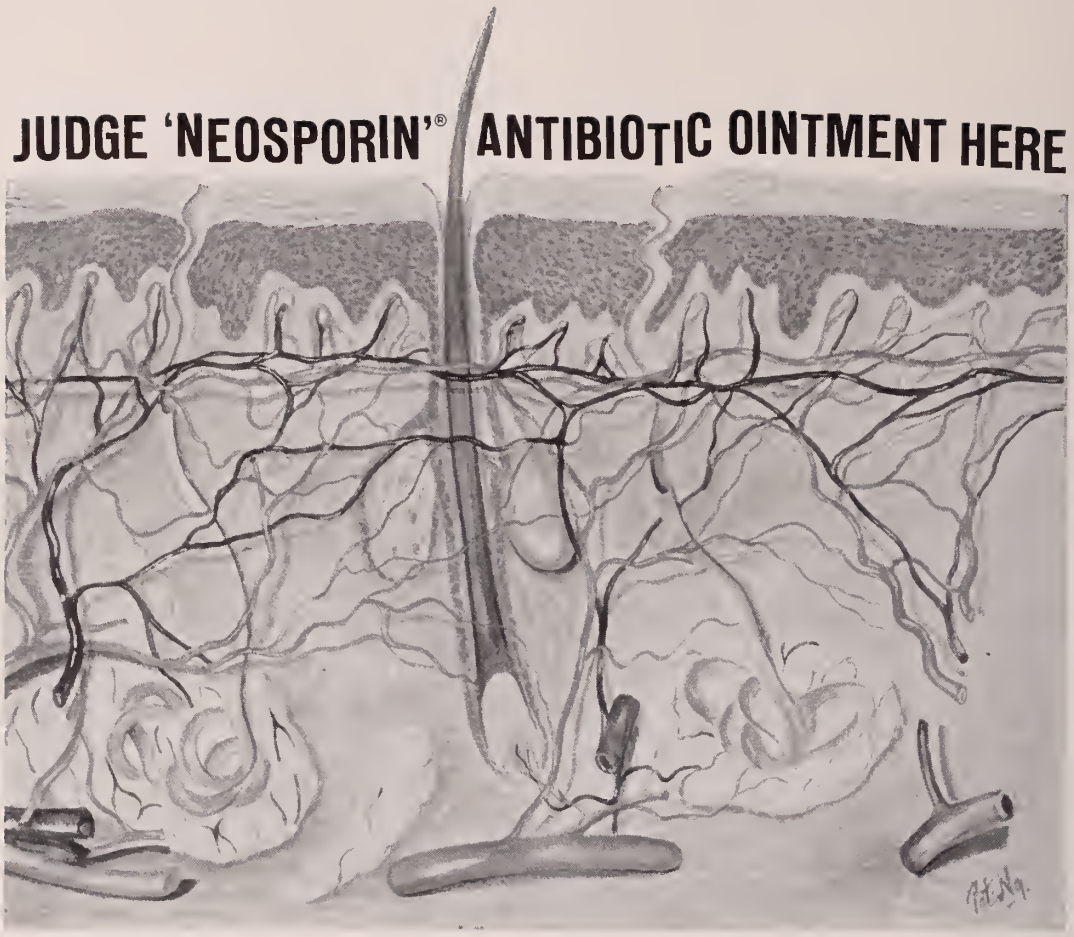

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CALENDAR OF MEETINGS

Wisconsin

1962

Nov. 1: Postgraduate Course on Surgical Emergencies Confronting the General Practitioner, University of Wisconsin Medical School, Madison.

Nov. 8: SMS teaching program on Clinical Electrocardiography, St. Mary's Hospital, Rhinelander.

Nov. 9–10: State Medical Society of Wisconsin Council Meeting, Minneapolis, Minn.

Nov. 14–15: Scientific meeting of The Medical Society of Milwaukee County, Milwaukee County Hospital, Milwaukee.

Nov. 15: SMS teaching program on Clinical Electrocardiography, Lakeside Methodist Hospital, Rice Lake.

Dec. 12–13: Postgraduate Course on the Nonoperative Therapy of Malignancy, Marquette University School of Medicine, Milwaukee.

1963

Jan. 10: Postgraduate course on Some Common Dermatologic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Feb. 7: Postgraduate course on Topics of Current Interest in the Care of the Newborn, University of Wisconsin Medical Center, Madison.

Feb. 13–14: Postgraduate course on Recent Advances in Gynecology and Obstetrics, Marquette University School of Medicine, Milwaukee.

Mar. 7: Postgraduate course on Some Orthopedic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Mar. 7–9: Postgraduate course on The Hemiplegic Patient, University of Wisconsin Medical Center, Madison.

Mar. 21–23: Postgraduate course on Advances in Immunology and Hypersensitivity, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

Out-of-State

1962

Oct. 28–31: Annual convention of the American College of Gastroenterology, Morrison Hotel, Chicago.

Oct. 29–Nov. 2: Postgradaute course, The Rheumatic Diseases—Pathology, Diagnosis and Treatment, American College of Physicians, Harvard Medical School, Boston, Mass.

Oct. 31–Nov. 2: Interscience Conference on Antimicrobial Agents and Chemotherapy, American Society for Microbiology, Morrison Hotel, Chicago.

Nov. 1–2: American Rhinologic Society annual meeting, Statler Hilton Hotel, Los Angeles.

Nov. 1–3: Academy of Psychosomatic Medicine annual meeting, Radisson Hotel, Minneapolis, Minn.

Nov. 1–3: Annual Course in Postgraduate Gastroenterology of the American College of Gastroenterology, Morrison Hotel, Chicago.

Nov. 3–4: State Medical Journal Conference, Denver, Colo.

Nov. 9: Annual symposium, Diabetes Association of Greater Chicago, Passavant Memorial Hospital, Chicago.

Nov. 10–11: North Central Medical Conference, Minneapolis, Minn.

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

1963

Jan. 24–25: Postgraduate course on Blood Vessels and Problems of Thromboembolism—Diagnosis and Treatment, American College of Physicians, Cornell University Medical College and the New York Hospital, New York.

Feb. 11–15: Postgraduate course on Modern Physiological Concepts of Cardiovascular Disease, Presbyterian Medical Center, American College of Physicians, Presbyterian Medical Center, San Francisco, Calif.

Mar. 4–6: Meeting of Canadian-American Medical and Dental Ski Association, Iroquois Mountain, Brimley, Mich.

Medical Meetings

Postgraduate Courses

American Medical Association

The 1962 Clinical Meeting of the American Medical Association will be held November 25 to 28 at Los Angeles, California. Convention headquarters will be the Biltmore Hotel and the scientific sessions will be held in the Shrine Auditorium.

An attendance of 12,000 is anticipated, half of them physicians. General arrangements are under the direction of Wilbur Bailey, M.D., past president of the Los Angeles County Medical Association and of the California Medical Society.

In an unprecedented Sunday afternoon scientific session on the opening day of the clinical meeting, November 25, top authorities in various aspects of air pollution will present papers giving the latest findings in this area. The program, entitled "Air Pollution and Pulmonary Disease," will feature six formal presentations. Luther L. Terry, M.D., U. S. surgeon general, will moderate a panel discussion at the conclusion of the afternoon. Reginald H. Smart, M.D., Los Angeles, will be moderator of the entire air pollution program.

More than 100 papers will be presented on the scientific program and more than 200 industrial and scientific exhibits will be displayed at the Shrine Auditorium.

Highlights of the program are as follows: Sunday afternoon—air pollution and pulmonary disease; Monday morning—viral hepatitis, cineradiography, general surgery, clinical nuclear medicine; Monday afternoon—new approaches to depression and suicide, anesthesiology, thoracic surgery, disturbances of growth in children; Tuesday morning—etiology and pathogenesis of cancer, forensic medicine in clinical practice, urology; Tuesday afternoon—chemotherapy of cancer, neurosurgical program, gynecological and obstetrical program; Wednesday morning—medical management of cardiovascular disease, symposium on dermatologic surgery, viruses; Wednesday afternoon—aerospace medicine, orthopedics, ear, nose and throat.

The program will be published in its entirety in the October 27 issue of the *Journal of the American Medical Association.*

American Academy of Dermatology

A one-day Symposium on Cosmetic Aspects of Dermatology December 4 will be sponsored by the Committee on Cosmetics of the American Medical Association as a part of the program of the annual meeting of the American Academy of Dermatology to be held in Chicago.

COOK COUNTY GRADUATE SCHOOL OF MEDICINE

Continuing Education Courses

STARTING DATES—FALL, 1962

Surgical Technic, Two Weeks, November 5

Surgery of Colon and Rectum, One Week, November 26

Vaginal Approach to Pelvic Surgery, One Week, Dec. 17

Gynecology, Office and Operative, Two Weeks, Nov. 5

Obstetrics, General and Surgical, Two Weeks, Nov. 26

Urology, Two Weeks, October 29

Proctoscopy and Sigmoidoscopy, One Week, Oct. 29, Dec. 17

Varicose Veins, One Week, Oct. 29, Dec. 17

General Surgery, One Week, October 29

Advances in Medicine, One Week, October 15

Advances in Surgery, One Week, December 10

Blood Vessel Surgery, One Week, October 22

Board of Surgery Review, Part I, Two Weeks, Nov. 5

Board of Surgery Review, Part II, Two Weeks, Nov. 26

Diagnostic Radiology, Two Weeks, October 29

Basic Internal Medicine, Two Weeks, November 5

Management of Common Fractures & Dislocations, One Week, December 3

Board of Internal Medicine Review, Part II, One Week, December 3

Information concerning numerous other continuation courses available upon request.

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MEDICAL MEETINGS *continued*

American Society for Microbiology

The American Society for Microbiology will sponsor the 1962 Interscience Conference on Antimicrobial Agents and Chemotherapy to be held at the Morrison Hotel in Chicago October 31 to November 2. Presentations will be made in the areas of infectious diseases, clinical evaluation of antibiotics, synthetic antimicrobials, chemistry of antibiotics, new antibiotics, cancer chemotherapy, cephalosporins, general antibiotics, and in vitro activity of antibiotics. The conference is open to all scientists and physicians interested in the field.

University of Wisconsin Postgraduate Courses

The following postgraduate courses have been scheduled for 1963 by the University of Wisconsin Medical Center:

Some Common Dermatologic Problems Occurring in General Practice, January 10.

Topics of Current Interest in the Care of the Newborn, February 7.

Some Orthopedic Problems Occurring in General Practice, March 7.

The Hemiplegic Patient, March 7–9.

Advances in Immunology and Hypersensitivity, March 21–23.

Frequent Gynecologic Problems Occurring in General Medical Practice, April 4.

Economic Problems Facing Hospitals, April 5–6.

Renal Disease in Childhood, April 25–27.

Common Problems in Ear, Nose, and Throat arising in General Practice, May 2.

For further information write: Coordinator, Postgraduate Program in Medical Education, The Wisconsin Center, 702 Langdon Street, Madison 6, Wis.

Marquette University Postgraduate Courses

Marquette University School of Medicine has scheduled the following 1963 postgraduate courses to be given at the Milwaukee County Hospital:

Recent Advances in Gynecology and Obstetrics, February 13–14.

Recent Advances in Hematology, April 23–25.

American College of Physicians

The following postgraduate courses have been scheduled by the American College of Physicians for 1963:

Diseases of the Blood Vessels and Problems of Thromboembolism—Diagnosis and Treatment, Cornell University Medical College and The New York Hospital, New York, January 21–25.

Modern Physiological Concepts of Cardiovascular Disease, Presbyterian Medical Center, San Francisco, Calif., February 11–15.

Physical Methodology in Medical Research, Massachusetts Institute of Technology, Cambridge, Mass., March 4–8.

Recent Advances in Cardiovascular Disease, The Mount Sinai Hospital, New York, March 18–23.

Physiological Aspects of Cardiopulmonary Disease, Indiana University Medical Center, Indianapolis, Ind., May 20–24.

Current Topics in Internal Medicine, State University of Iowa, Iowa City, Ia., June 10–14.

Internal Medicine: Current Physiological Concepts in Diagnosis and Treatment, University of Cincinnati College of Medicine, Cincinnati, Ohio, June 24–28.

The Psychosomatic Illnesses, University of Colorado Medical Center, Denver, Colo., June 24–28.

Tuition fee for each course is: Members, $60; Nonmenbers, $80. Registration forms and requests for information should be directed to: Edward C. Rosenow, Jr., M. D., Executive Director American College of Physicians, 4200 Pine Street, Philadelphia 4, Pa.

American College of Chest Physicians

The following meetings are planned by the American College of Chest Physicians during 1963:

Seventh International Congress on Diseases of the Chest, New Delhi, India, February 20–24.

Twenty-ninth Annual Meeting, Atlantic City, June 13–17.

Interim Session, Portland, Oregon, November 30–December 1.

American Industrial Health Conference

The 1963 American Industrial Health Conference will be held March 18–21 in Washington, D. C. The Conference is comprised of the annual meetings of the Industrial Medical Association and the American Association of Industrial Nurses. Further information may be obtained from the American Industrial Health Conference, 55 East Washington St., Chicago 2, Ill.

American Society of Anesthesiologists

The American Society of Anesthesiologists will hold its Biennial Western Conference on Anesthesiology at the Hawaiian Village in Honolulu March 25–29, 1963.

University of Iowa Postgraduate Courses

Postgraduate conferences on "New Concepts and Therapy in Hypertensive Disease" and "Respiratory Diseases" will be held November 30 at the State University of Iowa College of Medicine, Iowa City. Each conference will be one-half day.

Such topics as "Workup of the Hypertensive Patient," "Salt, Fat and Hypertension," and "Problems of the Hypertensive and His Physician" will highlight the cardiac conference.

Guest speakers will be Dr. Lewis K. Dahl, head of the Research Medical Service, Brookhaven National Laboratory, New York, and Dr. John H. Laragh, associate professor of clinical medicine at Columbia University College of Physicians and Surgeons.

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1962 MILWAUKEE MEDICAL CONFERENCE

Wednesday and Thursday—November 14 and 15

William L. Coffey Auditorium—Milwaukee County Hospital

Sponsored by The Medical Society of Milwaukee County in cooperation with Marquette University School of Medicine; Milwaukee County Hospital; Veterans Administration Hospital—Wood; Milwaukee Children's Hospital; Milwaukee Academy of General Practice; Milwaukee Specialty Societies; and the Speakers Service of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

REGISTRATION OPEN TO ALL PHYSICIANS. Registration Fee: $5.00. No fee for residents, interns, students. Acceptable for 12 hours Category I credit, American Academy of General Practice.

WEDNESDAY, NOVEMBER 14

12 N. Registration—Lobby and 2nd floor entrance, Coffey Auditorium (continues throughout program)

P.M.

12:30 WELCOME

Edwin H. Ellison, M.D., Chairman, program committee, Second Milwaukee Medical Conference

Mr. Duane Johnson, Administrator, Milwaukee County Hospital

John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine

Roman E. Galasinski, M.D., President, The Medical Society of Milwaukee County

MEDICAL AND SURGICAL DISEASES OF THE ABDOMEN AND PELVIS

Roman E. Galasinski, M.D., presiding

12:45 Intractable Diarrhea as the Presenting Complaint in the Zollinger–Ellison Syndrome, Medical–Surgical Grand Round,

William W. Engstrom, M.D., Moderator; Case Presentation, *Bruce Stoehr, M.D.;* X-ray Findings, *Robert W. Byrne, M.D.;* Movie of Patient Illustrating Preoperative Status, Cine-fluorographic Studies, Operative Findings and Results, *Edwin H. Ellison, M.D.*, and *John R. Amberg, M.D.;* Discussion, *Henry Harkins, M.D.*, Seattle, Wash.

1:45 Diagnosis and Management of the Pelvic Mass, *Richard Mattingly, M.D.*

2:05 Discussion

2:15 A Revised Combined Operation for Duodenal Ulcer: Clinical Applications, *Henry Harkins, M.D.*, Seattle, Wash.

2:45 Discussion

3:00 Coffee break

THE PROBLEM OF VOMITING IN EVERYDAY PRACTICE

Robert A. Frisch, M.D., president-elect, The Medical Society of Milwaukee County, presiding

A Symposium on Vomiting, *Konrad H. Soergel, M.D.*, Moderator

3:30 Pathogenesis of Vomiting, *M. C. F. Lindert, M.D.*

3:45 Pathologic Physiology of Vomiting, *Henry Harkins, M.D.*, Seattle, Wash.

4:00 Fluid and Electrolyte Replacement in the Vomiting Patient, *Edward J. Lennon, M.D.*

4:15 Management of Vomiting in the Semiconscious Patient, *Jay J. Jacoby, M.D.*

4:40 Open panel discussion

5:00 Adjournment

6:30 to 8:30 Reception at the "After Deck" of the Coach House, 1926 W. Wisconsin Avenue. Registrants will receive a complimentary ticket to the reception at the time of their registration. Tickets will admit the physician and his wife. PHYSICIANS MAY REGISTER FOR THE MEDICAL CONFERENCE AT THE RECEPTION.

THURSDAY, NOVEMBER 15

RECENT ADVANCES IN MEDICAL KNOWLEDGE

James M. Sullivan, M.D., immediate past president, The Medical Society of Milwaukee County, presiding

A.M.

10:00 Measurement and Management of Obesity, *Laurence H. Kyle, M.D.*, Washington, D. C.

10:30 Discussion

10:45 Current Concepts of Diabetes, *Norman H. Engbring, M.D.*

(continued on next page)

The afternoon conference on chest disease will include talks on skin tests in the diagnosis of chest disease, presentations of the latest research on chest disease, and a chest and infectious disease clinic. Guest faculty will include Dr. Arthur M. Olsen, consultant in medicine, Mayo Clinic, Rochester, Minn., and Dr. William W. Stead, professor of medicine at Marquette University School of Medicine, Milwaukee.

A postgraduate conference on pediatric surgical problems will be held at the State University of Iowa College of Medicine on December 4 and 5. Sponsored by the Department of Surgery, the conference will begin on the evening of December 4 with registration and dinner, followed by presentations and discussion of cases for operative clinics and demonstrations which will be held the next morning. Operations will demonstrate pediatric problems in abdominal, chest, thoracic, urologic, and reconstructive surgical fields.

Closed circuit television will be used in the demonstrations. Other discussions will include such topics as congenital diaphragmatic hernia, acute trauma in childhood, acute appendicitis in infancy and childhood, and indications for urologic investigations in children. One of the nation's outstanding pediatric surgeons, Dr. Clifford D. Benson, will be a guest faculty member. He is a clinical associate professor of surgery at Wayne State University Medical School and surgeon-in-chief at Children's Hospital of Michigan in Detroit.

For registration and program materials on above conferences, write to John A. Gius, M.D., Director, Postgraduate Medical Studies, Office of the Dean, College of Medicine, Iowa City, Iowa.

Marquette Postgraduate Course

Marquette University School of Medicine, in cooperation with the Milwaukee County Hospital, will present a postgraduate course in "Nonsurgical Treatment of Malignancy" on December 12 and 13 in Room 232 of the Milwaukee County Hospital, 8700 West Wisconsin Avenue, Milwaukee. Director of the course is John D. Hurley, M.D. Reservations should be made with: Joseph W. Rastatter, M.D., Director of Postgraduate Medical Education Programs, 8700 West Wisconsin Avenue, Milwaukee 13, Wis.

1962 Milwaukee Medical Conference continued

11:05 Discussion

11:15 Recess

A SYMPOSIUM ON IRREVERSIBLE SHOCK —ROLE OF CATECHOLAMINES—VALUE OF LOW MOLECULAR DEXTRAN, *Harold F. Hardman, M.D., Ph.D.,* Moderator

11:30 The Physicochemical and Pharmacologic Properties of Catecholamines, *Harold F. Hardman, M.D., Ph.D.*

11:45 Protection Against Traumatic Shock by Sympathetic Nerve Blocking Agents, *Bert K. P. Lum, M.D., Ph.D.*

12 N. Tissue Catecholamines in Hemorrhagic Shock, *Dean Calvert, Ph.D.*

P.M.

12:15 Use of Low Molecular Dextran in Prevention of Irreversible Hemorrhagic Shock, *Derward Lepley, Jr., M.D.*

12:30 Discussion

1:00 Lunch—Dutch Treat, Cafeteria, Milwaukee County Hospital.

EVERYDAY MEDICAL PROBLEMS

Robert E. Callan, M.D., past president, Wisconsin Academy of General Practice, presiding

1:45 A Change in the Personality—Functional or Organic?, *Eugene S. Turrell, M.D.*

2:05 Discussion

2:15 Metabolism and Hypometabolism, *Laurence H. Kyle, M.D.,* Washington, D. C.

2:45 Discussion

3:00 Pathogenesis and Treatment of Pyelonephritis, *Benjamin I. Heller, M.D.*

3:20 Discussion

3:30 Coffee break

MEDICAL AND SURGICAL PROBLEMS OF THE CHILD

Ted S. Buszkiewicz, M.D., president, Milwaukee Pediatric Society, presiding

3:45 The Significance of Serum Sodium Concentration, *Gerald A. Kerrigan, M.D.*

4:05 Discussion

4:15 A Panel Discussion on the Practical Aspects of Correctable Congenital Lesions, *William H. Frackelton, M.D.,* Moderator; Panelists: *John C. Peterson, M.D.,* pediatrician; *Marvin Glicklich, M.D.,* pediatric surgeon; *Bruce J. Brewer, M.D.,* orthopedic surgeon; *V. B. Hyslop, M.D.,* plastic surgeon.

5:15 Adjournment

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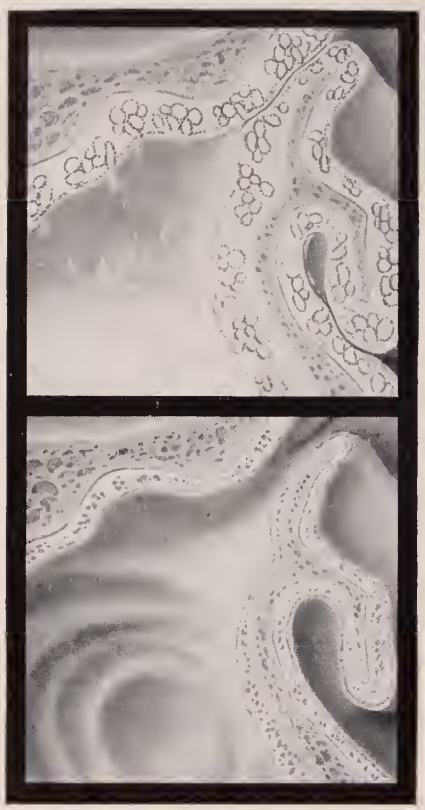

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In sinusitis, the mucous membrane becomes hyperemic and edematous, lymph glands and goblet cells hyperactive. Ostium is closed by edema and secretions cannot drain freely.

The normal sinus
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1. Grant, L. E.: Coryza and nasal sinus infections, **Clin. Med. & Surg.** 42:121, March, 1935. 2. Putney, F. J.: Sinus infection, in Conn, H. F. (Ed.): Current Therapy 1952, Philadelphia, W. B. Saunders Company, 1952, p. 110. 3. Simonton, K. M.: Current treatment of sinusitis, **Journal-Lancet** 79:535, Dec., 1959.

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the Wisconsin Medical Journal

Official Publication of THE STATE MEDICAL SOCIETY OF WISCONSIN

Vol. 61, No. 11—NOVEMBER 1962

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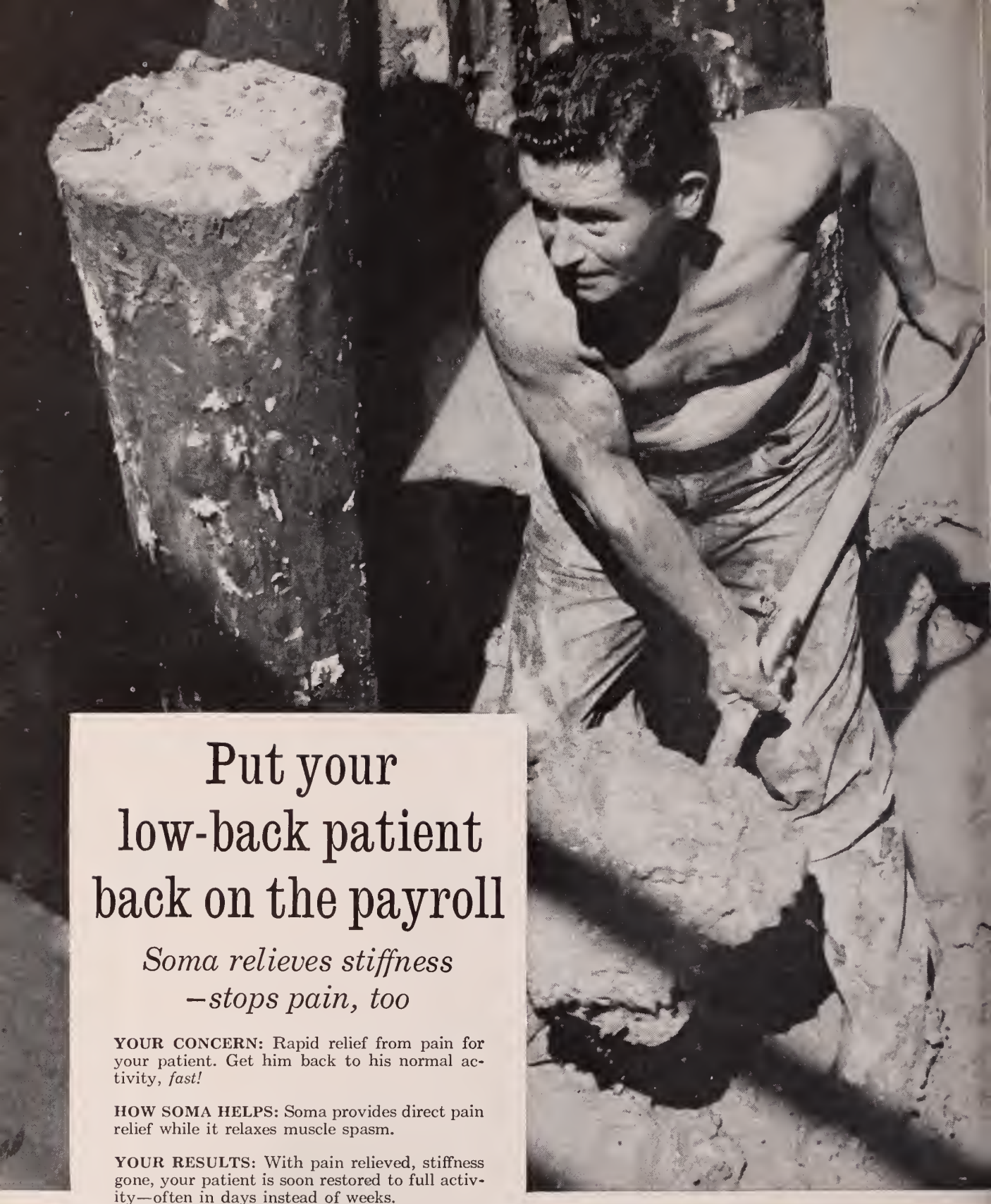

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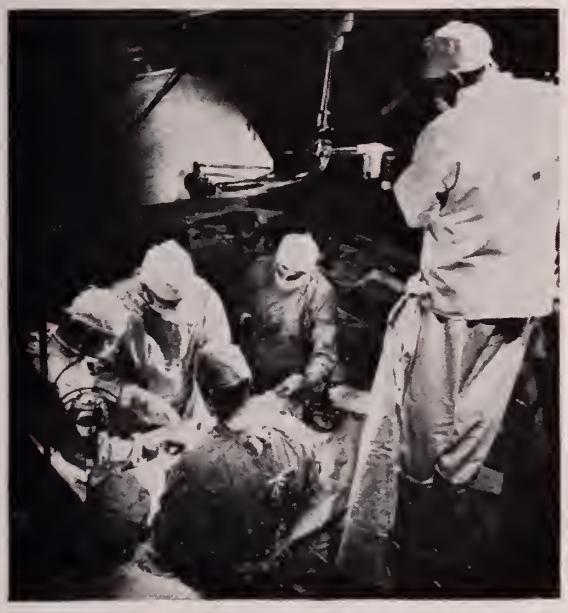

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Letters of Interest

MEDICARE ELIGIBILITY

To SMS:

The retention of certain servicemen beyond their normal date of expiration of active duty tours has been directed by the Secretary of Defense. Implementation poses many problems. Among them is the valid identification of the extendees' dependents who will remain eligible for certain benefits while their sponsors remain on active duty.

The extension of tours of duty may result in some dependents being without a valid Identification Card for some time. The basis of identification of dependents is, as you know, the Uniformed Services Identification and Privilege Card (DD Form 1173). Each card carries an expiration date of eligibility. This date, in the case of dependents of noncareer personnel, is the same as the expected expiration date of the sponsor's tour of active duty.

In the past, the "expiration date" on the ID Card has been the governing factor in determining that eligibility still exists. Since the involuntary extension of the tours of duty of many servicemen is effective almost immediately, the probability exists that some still-eligible dependent wives and children may apply for civilian medical care to which they are still entitled. They may not, however, have in their possession the required proof of their eligibility.

No change is contemplated in the provision of our contract which states that claims may not be processed for payment until the dependents have proven their eligibility to receive care. Service personnel will be advised that it is their responsibility to take necessary action to "update" the evidence of dependents eligibility.

It is most probable, however, that some dependents will be in need of authorized medical care from civilian sources prior to the time this action has been completed. In such cases, the dependent has been instructed to explain the situation to the physician and hospital authorities. They have been advised to present, if available, some tangible evidence such as allotment checks, official orders, directives, or personal letters which state the pertinent facts to the physician or hospital to help support the dependent's claim of continued eligibility.

This office is not empowered to broaden the "good faith" aspect of our contract. The number of dependents temporarily "unidentified" who require medical benefits will not be large.

In view of the situation at hand, I would appreciate your assistance in encouraging physicians and hospitals to exercise patience and understanding during the next several months when their services are requested by dependents of these extendees.

I must emphasize, however, that no claims may be processed for payment unless the dependent has provided a valid DD Form 1173 or a statement of eligibility as required by our contract.

BRYAN C. T. FENTON
Colonel, MC, USA
Executive Director
Office for Dependents' Medical Care
Office of the Surgeon General
U. S. Army

(EDITOR'S NOTE: A detailed explanation of this letter appears in the *Medical Forum* section of this issue.)

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County Society Proceedings

BARRON–WASHBURN–SAWYER–BURNETT

A rheumatic fever and congenital heart disease clinic was held in Rice Lake October 10 under the joint sponsorship of the Wisconsin Heart Association and the Barron–Washburn–Sawyer–Burnett County Medical Society. *Dr. George J. Griese,* pediatric cardiologist, and *Dr. Dean A. Emanuel,* internist, both of Marshfield, examined patients who were referred to the clinic by their physicians.

BROWN

An open house at the offices of *Drs. Richard L. Myers* and *D. W. Shea* preceded the October 11 meeting of the Brown County Medical Society in the Northland Hotel in Green Bay. Following dinner, *Dr. M. J. Javid,* of the University of Wisconsin Medical School, Madison, spoke on "Management of Head Injuries." Other guest speakers were Col. E. A. Heffner, M. D., USAF, and Lt. Col. William B. Flatow, USAF.

CHIPPEWA

Members of the Chippewa County Medical Society heard *Dr. Robert O. Johnson,* Madison, speak on "Cancer of the Colon" at their October 2 meeting at the Hotel Northern in Chippewa Falls. Doctor Johnson's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

CLARK

Dr. G. G. Shields, district health officer, Wisconsin Rapids, discussed recent developments in the use of oral polio vaccine at the September meeting of the Clark County Medical Society held at the Neillsville Memorial Hospital. A committee has been appointed to carry out a countywide immunization program, but it was decided to delay the program until details can be clarified.

CRAWFORD

The Crawford County Medical Society in cooperation with the Public Health Nursing Services set up 10 tuberculin skin testing centers for children in grades 1 through 4 and 7 through 11 in Crawford county during October and the first week in November.

DANE

Dr. Robin N. Allin, Madison, was elected and installed as president of the Dane County Medical Society at its meeting at the State Medical Society building in Madison October 9. Other newly elected officers are: *Dr. Palmer Kundert,* president-elect; *Dr. Karl Siebecker,* vice-president; and *Dr. Gordon Davenport,* secretary-treasurer, all of Madison.

Newly elected trustees are *Dr. Eugene J. Nelson,* Sun Prairie, and *Dr. Thomas Heighway,* Middleton.

DOUGLAS

Dr. Enzo Krahl and *Dr. James P. McGinnis,* both of Superior, were co-chairmen of the October 4 meeting of the Douglas County Medical Society held in the Student Union of Superior State College in Superior. Purpose of the meeting was to exchange information concerning the economics of present day medical care.

GREEN LAKE–WAUSHARA

Members of the Green Lake—Waushara County Medical Society heard *Dr. Frank C. Stiles,* Monroe, speak on "Fluid Therapy in Children" at their September meeting at Wautoma. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the State Board of Health.

JEFFERSON

Dr. R. F. Schilling, Madison, professor in the department of medicine, University of Wisconsin Medical School, talked on "Effective Therapy in Treatment of Anemia" at the October meeting of the Jefferson County Medical Society at Meadow Springs Country Club, Jefferson. His appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Merck Sharp & Dohme Postgraduate Program.

KENOSHA

"Cancer of the Colon" was the topic on which *Dr. William Wolberg,* Madison, spoke before the Kenosha County Medical Society on October 4 at the Elks Club, Kenosha. The appearance of Doctor Wolberg, who is an instructor in the department of surgery, University of Wisconsin Medical School, was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin Division of the American Cancer Society.

Physicians whose names appear in italic are members of the State Medical Society.

COUNTY SOCIETY PROCEEDINGS *continued*

MANITOWOC

The Manitowoc County Medical Society and the Manitowoc County Health Committee have scheduled a countywide immunization program for the prevention of diphtheria, whooping cough and tetanus during October, November, and December. All children between the ages of 6 months to 12 years are invited to participate.

MARINETTE–FLORENCE

A series of training classes in community disaster procedures, sponsored by Civil Defense, began October 4 at Marinette Vocational School under the direction of the Marinette–Florence County Medical Society.

MILWAUKEE

The Medical Society of Milwaukee County, through a subcommittee of the program committee, is working with representatives of WTMJ–TV to plan on-the-spot video tapings of research being conducted in Milwaukee as well as live interviews for the "Today for Women" program seen from 9 to 10 a. m., Monday through Friday. Members of the subcommittee are: *Drs. William H. Frackelton,* chairman; *George A. Hellmuth, William F. Hovis, Jr., Mischa J. Lustok,* and *Wilson Weisel.*

Research being carried on at the Marquette University School of Medicine, Milwaukee County Hospital, and the Veterans Administration Hospital, Wood, will be featured on the program. Interviews will be arranged with physicians visiting the city from other areas. The first program in the series was presented September 26 when Beulah Donohue of WTMJ–TV interviewed Eugene S. McDonough, Ph. D., professor of biology at Marquette University, on the short and long-term effects of radiation.

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PORTAGE

Dr. Sture A. M. Johnson, Madison, professor in the department of dermatology at the University of Wisconsin Medical School, spoke on "What's New in Treatment of Skin Diseases" at the October meeting of the Portage County Medical Society held at Stevens Point.

Doctor Johnson's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from Merck Sharp & Dohme Postgraduate Program.

SAUK

The Sauk County Medical Society met in Baraboo October 9 to hear *Dr. R. D. Lange,* Madison, speak on "Common Problems of the Ears, and Hearing Problems of School Children."

WAUKESHA

The Waukesha County Medical Society and the Waukesha County Health Department cooperated November 1 in a communitywide program of immunization using a weakened live measles vaccine not yet available to private physicians. The program was part of the testing of the vaccine required before its certification by the National Institutes of Health.

About 10,000 children in Maryland, Virginia, and St. Joseph, Missouri, have been inoculated in programs headed by Dr. John Bulkely of the University of Maryland School of Medicine. The results have shown that about 97 per cent of the children vaccinated gained immunity to the disease.

The testing program required that blood samples be taken from one of every four children vaccinated in the program. Those who had blood samples taken November 1 must return November 29 to have another sample taken.

Dr. Eugene Frank, Oconomowoc, president of the Waukesha County Medical Society, stated that physicians support the evaluation that must be done under controlled conditions as a necessary prelude to bringing the new vaccine into use in physicians' offices.

WINNEBAGO

Dr. Henry A. Anderson Stevens Point, talked on "Tuberculosis Still a Problem" at the October meeting of the Winnebago County Medical Society held at Menasha.

Specialty Society Proceedings

American Academy for Cerebral Palsy

The American Academy for Cerebral Palsy elected the following officers for 1962–1963 at its 16th annual meeting October 5:

President: Dr. Russell Meyers, Iowa City, Ia.
President-elect: Dr. Eric Denhoff, Providence, R. I.
Vice-president: Dr. Herman Yannet, Southbury, Conn.
Secretary: Dr. J. D. Russ, New Orleans, La.
Treasurer: Dr. J. W. Hillman, Nashville, Tenn.
Members of Executive Committee: Drs. H. O. Marsh, Wichita, Kan., and H. A. Engle, Miami Beach, Fla.

The 17th annual meeting of the American Academy for Cerebral Palsy will be held in Dallas, Texas, at the Sheraton–Dallas Hotel November 24 through 27, 1963.

Wisconsin Psychiatric Association

The Northern Branch of the Wisconsin Psychiatric Association was host to the state group on October 27 at the Fountain Park Motor Inn, Sheboygan. The Council meeting was followed by an afternoon meeting on group therapy. During the evening, Dr. George Andrews, Wausau, spoke about his experiences with Doctor Schweitzer in Africa.

"Psychiatric Emergencies" will be the theme of the annual scientific meeting of the Association to be held at the Dell View Hotel, Lake Delton, the weekend of February 1, 1963.

Milwaukee Academy of Medicine

Dr. A. McGehee Harvey, professor of medicine at Johns Hopkins University, Baltimore, Md., spoke on "Some Current Concepts of Auto-immune Disease" at the October 16 meeting of the Milwaukee Academy of Medicine at the University Club, Milwaukee.

Wisconsin Society of Internal Medicine

Dr. George E. Gutmann, Janesville, was recently elected secretary-treasurer of the Wisconsin Society of Internal Medicine. Doctor Gutmann is a charter member of the organization and has served on the Society's governing Council since 1959. He has served as program chairman for the Society's past two annual meetings and will continue in this capacity for the 1963 annual meeting.

Physicians whose names appear in italic are members of the State Medical Society.

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News of Wisconsin Physicians

Dr. Juster Retires, Takes New Position

Dr. Eugene M. Juster retired in September after practicing medicine in Madison for more than 36 years. The following week he was appointed medical director of CUNA Mutual Insurance Society, Madison.

Doctor Juster had served as medical consultant of CUNA Mutual on a part-time basis since the Society was organized in Madison in 1935 as the credit union life insurance organization.

A native of Milwaukee and a veteran of World War I, Doctor Juster is an accomplished violinist and in his student days at the University of Wisconsin was a member and director of Haresfoot Club orchestras. He also played with the Al Thompson orchestras of years ago. He is a member of the American Academy of Dermatology.

Dane County Auxiliary Hears Dr. Allin

Dr. Robin Allin, Madison, president of the Dane County Medical Society, was the main speaker at the fall luncheon of the Dane County Medical Auxiliary October 1 at the Stoughton Country Club.

Dr. Krohn Attends European Meetings

In addition to attending the biennial meeting of the International College of Surgeons in New York City in September, *Dr. Robert Krohn*, Black River Falls, also attended the European Federation of the International College of Surgeons presented in several countries of Europe with the principal meeting being held in Amsterdam, Holland.

Dr. Tenney Opens Lecture Series

Dr. H. Kent Tenney, Madison, began a six-meeting series of lectures on the "Emotional Growth of Children" October 10 at Scanlan Hall in Madison. The series is open to the public as a service of the Dane County Guidance Center and the Madison Adult School.

Dr. Russell Speaks to Health Council

Dr. William Russell, Sun Prairie, was the featured speaker at the fall meeting of the Sun Prairie Health Council on September 20.

Nurses Hear Dr. Lustok

Dr. Mischa Lustok, Milwaukee heart and lung specialist, spoke to registered nurses of Ozaukee county September 27.

Dr. Sehring Joins Clinic in Green Bay

Dr. Frederick G. Sehring, native of Joliet, Ill., has joined the West Side Clinic at Green Bay as a specialist in obstetrics and gynecology.

Doctor Sehring recently completed two years in the Air Force Medical Corps where he was chief of obstetrics and gynecology at Schilling AFB. He received his B. S. degree from Loras College in 1952 and his M. D. degree from Marquette University School of Medicine in 1956. After completing his internship at the University Hospitals of the State University of Iowa in 1957, he took three years of residency postgraduate training in the department of obstetrics and gynecology at the university.

Physicians whose names appear in italic are members of the State Medical Society.

Heads Sanatorium Superintendents Group

Dr. Louis Nezworski, of Mount Washington Sanatorium, Eau Claire, was named president of the Wisconsin Sanatorium Superintendents Association at its convention in Appleton in September. The 1963 meeting will be held at his hospital.

Thorp Doctors Take Michigan Posts

Drs. Philip and *Eleanora Jorgensen* are taking an indeterminate leave of absence from their practice in Thorp to accept appointments to positions in a Veterans Administration hospital in Detroit, Michigan.

Kiwanians Hear Dr. Matzke

Dr. Rudolph W. Matzke, Spooner, discussed psychosomatic medicines and treatment at a luncheon meeting of the Kiwanis club in Spooner in September.

Leaves Practice to Study Specialty

Dr. J. C. Belshe has resigned from the staff of the St. Croix Falls Clinic, where he has served for the past 12 years, to enter specialized training in anesthesiology at the University of Minnesota Hospital. Doctor Belshe is especially interested in the field of electrical anesthesiology.

Dr. Van Driest Talks on Saigon Project

Dr. John Van Driest, Sheboygan, who recently spent five weeks at Cho Ray Hospital in Saigon, South Vietnam, told about the orthopedic project there at a recent meeting in Sheboygan of physical therapists from all parts of the state.

Attend Course at U. of Minnesota

Dr. Lyle L. Olson, Darlington, recently attended a three-day course at the University of Minnesota Center for Continuing Study which was intended for coroners, medical examiners, and forensic pathologists and included discussions of all common forms

of accidental deaths. Dr. Clarence Strand, pathologist for the Memorial Hospital of Lafayette County, also attended the course.

Discusses Mental Hospital's Role

Dr. Leonard J. Ganser, Madison, presented medical points concerning the role which the county hospital will play in the future of the mentally ill in state communities in a panel discussion before the Winnebago County Association for Mental Health in September. Judge Eugene Topel, La Crosse, presented the legal aspects.

Doctors Park Grows in Appleton

Three of the six buildings planned for Docotors Park in Appleton have been completed and two of them are occupied by *Drs. Thomas M. Loescher, D. L. Meyers, Frank Wright, Jr., George Nichols, Jack G. Anderson*, and *Harold D. Danford*. The third contains a pharmacy and laboratory.

Physicians Join Associates in Practice

Dr. Jack Ramon Lees, a specialist in obstetrics and gynecology, has joined the medical staff of the Marshfield Clinic. He received his B. S. degree from North Dakota State College in 1952 and his M. D. degree from Northwestern University Medical School in 1956. After completing his internship at the Charles T. Miller Hospital in St. Paul, he served two years in the Air Force as a flight surgeon. Upon discharge in 1959 he entered the University of Minnesota Hospitals for specialized work in obstetrics and gynecology and concluded his work there in September.

Dr. Wayne L. McFadden, general practitioner, has joined the staff of the South Milwaukee Clinic. He recently completed a four-year tour of duty in the Army. He received his B. S. degree from Muskingum College at Concord, Ohio, in 1950 and his M. D. degree from the Ohio State University College of Medicine in 1954. After interning at St. Rita's hospital at Lima, Ohio, he had a general medical practice in Canton, Ohio, for three years and served on the staff of Aultman hospital there.

Sturgeon Bay Office Opened

Dr. Nicholas Wagener has opened an office in Sturgeon Bay for the practice of medicine during weekday afternoons and Friday evenings. He will continue to serve Baileys Harbor during the morning hours with offices in the village hall.

Presents Paper at International Congress

Dr. Richard H. Wasserburger, chief of cardiology at the Veterans Administration Hospital, Madison, and associate professor of clinical medicine, University of Wisconsin, presented a paper, "The Effect of Oral Potassium Salts in Differentiating Functional from Organic T-Waves," to the Seventh International Congress for Internal Medicine, Munich, Germany, October 6. He also presented his paper at a seminar at the University of Vermont Medical School September 28 and 29.

Dr. Gardner Rejoins Menomonie Clinic

Dr. Robert J. Gardner, who was associated with the Menomonie Clinic as a general practitioner from 1952 to 1958, rejoined the Clinic on October 1 to practice his specialty in general surgery. Doctor Gardner completed his surgical residency training in Chicago at hospitals affiliated with Northwestern University.

Physicians Attend Meetings

Dr. Robert O. Johnson, Madison, attended the Surgical Lung Adjuvant Program meeting in Boston October 7 and 8.

Dr. Milton Miller, Madison, spoke at the A. M. A. National Congress on Mental Illness and Health in Chicago on October 4. On September 26 he gave a guest lecture entitled "The Phenomenology of Maturity" at the Downy V. A. Hospital.

Dr. Hartwell G. Thompson, Jr., Madison, attended the Central Society for Neurological Research meeting at Grafton, Ill., October 5 to 8.

Dr. Peters Returns from Turkey

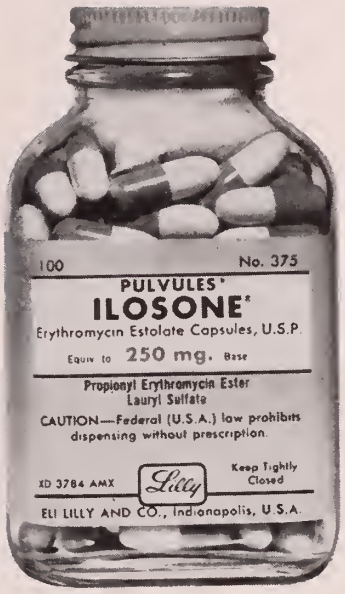
Dr. Henry A. Peters, Madison, returned recently from Turkey where he has conducted follow-up studies on porphyria patients treated in the last year. He also attended a Neurological Congress in Cologne, Germany, and gave a talk on porphyria in Oslo, Norway.

Dr. Kroncke Appointed Instructor

Dr. George M. Kroncke, Madison, has been appointed an instructor in the department of surgery at the University of Wisconsin Medical School. He also is a fellow in thoracic surgery. After receiving his M. D. degree from the University of Wisconsin in 1954, Doctor Kroncke interned at the Medical College of Virginia, Richmond, in 1954–55 and served from 1955 to 1959 as a resident in surgery at University Hospitals in Madison. He served as a staff surgeon at the U. S. Naval Hospital in Charlston, S. Car., from 1959 until his return to Madison.

Direct X-ray Technology Course

Drs. Emil Schultz and *T. D. Moberg*, Eau Claire, are directing an x-ray technology program at the Luther Hospital school, Eau Claire. The new program includes a 3-month academic course at the University of Minnesota and a 21-month course at the hospital. Students who complete the course will be qualified to take the board examination of the American Registry of X-Ray Technicians which is sponsored and sanctioned by the American College of Radiology and the American Medical Association.



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WISCONSIN PHYSICIANS *continued*

Dr. Cameron Joins Marshfield Clinic

Dr. A. B. Cameron, native of North Dakota, has joined the Marshfield Clinic as a surgeon. He earned his B. A. degree at Princeton University and his M. D. degree at Harvard Medical School. After interning at Ohio State University Hospital in Columbus, Doctor Cameron went on to earn his master of medical science degree. He then served the United States Public Health Service for two years in Columbus and since 1959 has been in surgical residency at the Ohio State University Hospital. He specialized in pediatric surgery.

Dr. Emanuel Speaks to Dietetic Group

Dr. Dean A. Emanuel, vice-president of the Marshfield Clinic Foundation for Medical Research and Education, spoke on "Dietary Factors and Heart Disease" at the fall meeting of the Northern Wisconsin Dietetic Association in Marshfield in September. Doctor Emanuel also accepted a check from the group for the Foundation.

Hospital Staff Elects Officers

Dr. John T. Siebert, Baraboo, has been elected president of the staff of physicians at St. Mary's Ringling hospital at Baraboo. Others elected to office include *Dr. M. F. Huth,* Baraboo, vice-president, and *Dr. H. L. Conley,* Wisconsin Dells, secretary-treasurer. Serving on the executive board are: Drs. Siebert, Huth, Conley, *C. R. Pearson, K. D. Hannan* and *A. C. Edwards,* the latter three also of Baraboo.

Wittenberg Clinic Has New Associate

Dr. John A. Gerdes has begun his practice in the Wittenberg Clinic in which he is associated with *Dr. M. A. Olson,* clinic owner who recently moved to Schofield to open a clinic there.

Dr. Minter to Leave Clinton

Dr. Donald L. Minter will close his practice in Clinton in March so that he may study at the Cook County Postgraduate School of Medicine, Chicago, and in Pennsylvania. On July 1, 1963, he will become a resident in internal medicine at Harrisburg Hospital, Harrisburg, Pa., which will include further training in heart diseases during the next three years.

Dr. Mohs Talks on Russian Trip

Wives of medical students of the University of Wisconsin heard *Dr. F. E. Mohs,* of the university surgery department, give an illustrated talk on "Medicine as Observed on a Trip to Russia" at their October meeting in Madison. Doctor Mohs also discussed National Health Service in England and medicine in France and Germany.

Work of Monroe Physicians Published

A paper entitled "Anterior Interbody Fusion in the Treatment of Certain Disorders of the Cervical Spine," which is the work of four physicians from The Monroe Clinic, was published in a recent issue of CLINICAL ORTHOPAEDICS, a quarterly medical journal.

In the past two years, *Dr. Eugene E. Herzberger* has performed 80 operations of the kind described. Concurring with him in the published paper were *Drs. Arthur Chandler,* who also did the art work; *Nathan E. Bear,* and *Leslie G. Kindschi.*

Doctor Herzberger presented his paper on "Treatment of Cervical Disc Disease and Cervical Spine Injury by Anterior Interbody Fusion" at the Congress of Neurological Surgeons in Houston, Texas, November 2. He gave the same paper at the American Medical Association meeting in Chicago last June.

Dr. Jacobson Honored by Gift

In recognition of the service *Dr. Lewis L. Jacobson,* Eagle River, has given their Minne–Wonka Lodge near Three Lakes, Mr. and Mrs. Leslie W. Lyon made a contribution of $50 to the Eagle River Memorial Hospital in his name. The Lyons are marking their 50th anniversary year.

Dr. Jordahl Assumes Hospital Post

Dr. Clarence Jordahl, Jr., who has been a research fellow for a year at the Graduate School of Medicine at the University of Pennsylvania, is filling the newly created position of director of medical education at Milwaukee County Hospital. He will coordinate the medical education program for about 25 members of the hospital's house staff, including interns and residents.

Fellows of American College of Surgeons

Twenty-two Wisconsin physicians were formally inducted as new Fellows of the American College of Surgeons at the 48th Clinical Congress of the world's largest organization of surgeons. They are: *Drs. A. Yale Gerol* and *John N. Richards,* Kenosha; Norman W. Crisp, Jr., *John K. Scott, Dean Barton Smith* and *Glen J. Stuesser,* Madison; *Earling O. Ravn, Jr.,* Merrill; *Victor M. Bernhard, Donald W. Calvy, James H. Casey, John D. Charles, Joseph C. Darin, David E. Davidoff, John J. Frederick, Derward Lepley, Jr.,* Robert T. McGarty, *Randle E. Pollard, A. G. Schutte* and *Leonard J. Schwade,* Milwaukee; *William J. Smollen,* Racine; *Richard B. Windsor,* Sheboygan; and *Albert J. Motzel, Jr.,* Waukesha.

Dr. Keiser Opens De Pere Office

Dr. Orris S. Keiser, physician and surgeon, has opened an office in De Pere. A graduate of Loma Linda University in California, Doctor Keiser was associated with the Swayze Clinic in Muscatine, Iowa, for more than seven years. He had previously

served as resident physician at a state penal institution for two years.

Dr. Hofbauer Joins Menomonee Falls Group

Dr. Thomas Hofbauer, 1956 graduate of Marquette University School of Medicine, has joined the staff of Medical Associates, Menomonee Falls. He completed his residency at Milwaukee County Hospital and served in the army hospital in Denver. He also served as an instructor at Marquette University.

Marquette-Jackson Clinic Speakers

Speakers at the 32nd annual postgraduate program given by Marquette University School of Medicine and the Jackson Clinic, Madison, included: *Drs. Thomas Wall, Gerson C. Bernhard* and *Mark J. Ciccantelli* from the Marquette faculty and Drs. *Oscar F. Foseid, H. C. Ashman, Robert A. Straughn, William B. Parsons, Jr., John H. Morledge, Barbara A. Brew* and D. William Hurst of the Jackson Clinic.

The postgraduate program, which was held at the Loraine hotel, Madison, on October 4, was arranged by Doctor Morledge and *Dr. Arnold S. Jackson* of the Clinic.

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Society Records

MEMBERSHIP REPORT AS OF SEPTEMBER 30, 1962

NEW MEMBERS

Henry C. Everett, 301 Troy Drive, Madison 4.

Thomas P. Forrestal, St. Luke's Hospital, Milwaukee.

Marshall R. Jennison, Milwaukee County Hospital, Milwaukee.

Byron A. Myhre, 763 North 18th Street, Milwaukee.

Kenneth P. Schroeder, 147 North State Street Berlin.

Donald S. Schuster, 222 North Midvale Boulevard, Madison.

Gojko D. Stula, 3615 West Oklahoma Avenue, Milwaukee.

Stanley F. Wyner, 122 East Gilman Street, Madison.

Thomas E. Zabors, Milwaukee County Hospital, Milwaukee.

CHANGES OF ADDRESS

Michael D. Ballard, Philadelphia, Pennsylvania, to 96 Lincoln Street, Portland, Maine.

Jacob J. Baron, to 1860 West Greenwood Road, Milwaukee 9.

Harvey H. Bernstein, to 2245 West Woodbury, Milwaukee.

James T. Botticelli, to 2510 North 86th Street, Milwaukee.

John Z. Bowers, San Francisco, to c/o Dr. Iso-o Horii, Dean, The Medical School, Kyoto University, Kyoto, Japan.

William A. Brah, Milwaukee, to 10425 West North Avenue, Wauwatosa 13.

Elvin M. Bremer, to 8969 North Iroquois Road, Milwaukee.

Harold G. Danford, to 424 East Longview Drive, Appleton.

Donald P. Davis, Berkeley, West Virginia, to 1812 Prospect Avenue, Erie, Pennsylvania.

Phillip J. Eisenberg, to 3402 West Wells, Milwaukee.

Joyce M. Eisenbraun, Milwaukee, to 417 South Orchard, Stillwater, Oklahoma.

Timothy T. Flaherty, to 2611A Durango Drive, Amarillo, Texas.

Robert A. Gruesen, Madison, to 6249 Avalon Lane East, Indianapolis 20, Indiana.

E. R. Hanson, Milwaukee, to 1605 Notre Dame Boulevard, Elm Grove.

*John P. Hartwick, Fayetteville, North Carolina, to Moble Army Hospital, Fort McClellan, Alabama.

H. J. Heath, Juneau, to 5252 El Cajon Boulevard, San Diego 15, California.

E. F. Hill, Salt Lake City, Utah, to 2720 Agnes Street, Eau Claire.

E. P. Huth, Milwaukee, to 1471 Lemon Bay Drive, Englewood, Florida.

Michael T. Jaekels, to 425 East Wisconsin Avenue, Milwaukee.

Eleanora Jorgensen, Thorp, to V. A. Hospital, Detroit, Michigan.

Philip B. Jorgensen, Thorp, to V. A. Hospital, Detroit, Michigan.

Maurice Kadin, Racine, to 10101 Hadley, Northridge, California.

*Bernard C. Korbitz, Madison, to USAF (MC), 3510 USAD Hospital, Randolph AFB, Texas.

J. R. Kuzdas, to 7635 West Oklahoma, Milwaukee.

O. M. Larimore, Detroit Lakes, Minnesota, to Richmond State Hospital, Richmond, Indiana.

R. M. Maynard, Wood, to V. A. Hospital, Seventh Street and Indian School Road, Phoenix, Arizona.

Elton Mendeloff, to 6110 West Capitol Drive, Milwaukee.

John F. Morrissey, Seattle, Washington, to 1300 University Avenue, Madison 6.

Marvin H. Olson, Wittenberg, to 1324 Schofield Avenue, Schofield.

Edward P. Onderak, Greendale, to 2200 West Kilbourn Avenue, Milwaukee.

A. J. Owens, to 152 West Wisconsin Avenue, Milwaukee.

Samuel G. Perlson, to 4831 North Ardmore, Milwaukee.

E. A. Pohl, to 2919 Oxford Road, Madison 5.

Jesus T. Querol, Black Creek, to Irving Zuelke Building, Appleton.

Maurice J. Reuter, Jr., Milwaukee, to 128 North Durkee Street, Appleton.

Roland J. Schacht, to 3935 North Bay Drive, Racine.

Clemens S. Schmidt, to 4421 Boulder Terrace, Madison 11.

W. W. Stebbins, Madison, to 222 - 8th Avenue North, St. Petersburg, Florida.

Donald J. Taylor, Madison, to 619 Main Street, Texarkana, Texas.

Howard M. Templeton, New Orleans, Louisiana, to General Delivery, Stevens Point.

Harry G. Walters, to 1430 Blaine Avenue, Racine.

J. D. Weinstein, Milwaukee, to 4602 Packard Avenue, Cudahy.

J. J. Zaun, Jr., Milwaukee, to Winchester.

*Military member.

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Saturday, November 3, 1962
Santa Barbara Biltmore Hotel

INDIANAPOLIS, INDIANA
Wednesday, November 7, 1962
The Marott Hotel

ANAHEIM, CALIFORNIA
Sunday, November 11, 1962
The Disneyland Hotel

KNOXVILLE, TENNESSEE
Thursday, November 15, 1962
Hotel Andrew Johnson

PHOENIX, ARIZONA
November 18, 1962
Westward Ho Hotel

NEW CITY, NEW YORK
Wednesday, November 28, 1962
Dellwood Country Club

LOS ANGELES, CALIFORNIA
November 29, 1962
Ambassador Hotel

GRAND RAPIDS, MICHIGAN
Saturday, December 1, 1962
Pantlind Hotel

NORFOLK, VIRGINIA
December 6, 1962
Golden Triangle Motor Hotel

DENVER, COLORADO
Sunday, January 13, 1963
The Cosmopolitan Hotel

FORT SMITH, ARKANSAS
Tuesday, January 15, 1963
The Holiday Inn

PORTLAND, OREGON
Thursday, January 31, 1963
The Sheraton-Portland Hotel

ANCHORAGE, ALASKA
Saturday, February 23, 1963
The Anchorage Westward Hotel

DETROIT, MICHIGAN
Wednesday, February 27, 1963
The Sheraton-Cadillac Hotel

WILMINGTON, DELAWARE
Saturday, March 9, 1963
Delaware Academy of Medicine

HUNTSVILLE, ALABAMA
Thursday, March 14, 1963
The Russel Erskine Hotel

FARGO, NORTH DAKOTA
Saturday, March 16, 1963
The Frederick Martin Hotel
(Moorhead, Minn.)

BELLINGHAM, WASHINGTON
Saturday, March 23, 1963
The Hotel Leopold

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CALENDAR OF MEETINGS

Wisconsin

1962

Dec. 12–13: Postgraduate Course on the Nonoperative Therapy of Malignancy, Marquette University School of Medicine, Milwaukee.

1963

Jan. 10: Postgraduate course on Some Common Dermatologic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Feb. 7: Postgraduate course on Topics of Current Interest in the Care of the Newborn, University of Wisconsin Medical Center, Madison.

Feb. 13–14: Postgraduate course on Recent Advances in Gynecology and Obstetrics, Marquette University School of Medicine, Milwaukee.

Mar. 7: Postgraduate course on Some Orthopedic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Mar. 7–9: Postgraduate course on The Hemiplegic Patient, University of Wisconsin Medical Center, Madison.

Mar. 21–23: Postgraduate course on Advances in Immunology and Hypersensitivity, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

Out-of-State

1962

Nov. 26–30: AMA Clinical Meeting, Los Angeles, California.

Dec. 4: Symposium on Cosmetic Aspects of Dermatology, American Academy of Dermatology annual meeting, Chicago.

1963

Jan. 21–25: Postgraduate course on Blood Vessels and Problems of Thromboembolism—Diagnosis and Treatment, American College of Physicians, Cornell University Medical College and the New York Hospital, New York.

Feb. 11–15: Postgraduate course on Modern Physiological Concepts of Cardiovascular Disease, Presbyterian Medical Center, American College of Physicians, Presbyterian Medical Center, San Francisco, Calif.

Mar. 4–6: Meeting of Canadian-American Medical and Dental Ski Association, Iroquois Mountain, Brimley, Mich.

Mar. 4–8: Postgraduate course on Physical Methodology in Medical Research, Massachusetts Institute of Technology, American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Mar. 8–9: AMA Medicolegal Symposium, Americana Hotel, Miami Beach, Florida.

Mar. 18–23: Postgraduate course on Recent Advances in Cardiovascular Disease, American College of Physicians, The Mount Sinai Hospital, New York.

Mar. 24–29: American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana of New York, New York City.

Mar. 25–29: American Society of Anesthesiologists Biennial Western Conference on Anesthesiology, Hawaiian Village, Honolulu.

Medical Meetings
Postgraduate Courses

Canadian–American Medical and Dental Ski Association

Officers of the Canadian–American Medical and Dental Ski Association for 1963 are:

President: Dr. D. D. Finlayson, Sault Ste. Marie, Michigan
President-elect: Dr. J. Hall, Sault Ste. Marie, Michigan
Vice-president: Dr. D. T. Conley, Marquette, Michigan
Secretary-treasurer: Dr. T. J. Trapasso, Sault Ste. Marie, Michigan

The meeting for 1963 will be March 4, 5 and 6 at Iroquois Mountain, Brimley, Michigan. Address inquiries to Dr. T. J. Trapasso, 816 Ashmun Street, Sault Ste. Marie, Michigan.

American College of Chest Physicians

On December 3 to 7, the American College of Chest Physicians in cooperation with the Industrial Medical Association will sponsor a postgraduate course on "Cardiopulmonary Diseases and Occupation" at the Statler Hotel in Detroit.

The fee for the course is $75 for members of the American College of Chest Physicians and $100 for nonmembers. Tuition includes luncheons.

American College of Allergists

The American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress will be held March 24 to 29, 1963 at Americana of New York, New York City. For further information, write to: John D. Gillaspie, M. D., Treasurer, 2141 14th Street, Boulder, Colorado.

American Academy of Dermatology

The relationship of modern day cosmetics to skin disorders will be analyzed at a one-day Symposium on Cosmetic Aspects of Dermatology December 4 in Chicago. The symposium will be sponsored by the Committee on Cosmetics of the American Medical Association as a part of the program of the annual meeting of the American Academy of Dermatology.

Raymond R. Susking, M. D., professor and head of the division of environmental medicine of the University of Oregon Medical School, Portland, is chairman of the AMA committee and in charge of the symposium.

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SURGICAL TECHNIC, Two Weeks, February 18, 1963
SURGERY OF COLON AND RECTUM, One Week, November 26
VAGINAL APPROACH TO PELVIC SURGERY, One Week, December 17
GYNECOLOGY, OFFICE & OPERATIVE, Two Weeks, April 1, 1963
OBSTETRICS, GENERAL & SURGICAL, Two Weeks, Nov. 26, March 11, 1963
PROCTOSCOPY & SIGMOIDOSCOPY, One Week, Dec. 17, Jan. 28, 1963
VARICOSE VEINS, One Week, Dec. 17, Jan. 28, 1963
GENERAL SURGERY, One Week, February 25, 1963
ADVANCES IN SURGERY, One Week, December 10
BOARD OF SURGERY REVIEW, PART II, Two Weeks, Nov. 26, Mar. 4, 1963
BASIC INTERNAL MEDICINE, Two Weeks, March 4, 1963
MANAGEMENT OF COMMON FRACTURES & DISLOCATIONS, One Week, Dec. 3
BOARD OF INTERNAL MEDICINE REVIEW, PART II, One Week, Dec. 3
BREAST & THYROID SURGERY, One Week, December 3
GALLBLADDER SURGERY, Three Days, March 11, 1963
SURGERY OF HERNIA, Three Days, March 14, 1963
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MEDICAL MEETINGS *continued*

Following the morning theme of "Scope and Current Problems of Cosmetic Dermatology," Irvin H. Blank, Ph. D., Harvard Medical School dermatology professor, will speak on "Cosmetics Versus Topical Therapeutic Agents"; Albert M. Kligman, M. D., of the University of Pennsylvania Medical School, will discuss "Bacteriostatic Agents in Cosmetics"; and John S. Strauss, M. D., Boston University School of Medicine dermatology professor, will talk on "Hormones in Cosmetics."

Cryil H. March, M. D., New York University Postgraduate Medical School dermatology teacher will speak on "Cosmetic Considerations in Dermatologic Disorders." Co-author with Dr. March is Victor H. Witten, M. D. Samuel Ayres, M. D., University of Southern California dermatology professor, will discuss "The Current Status of Superficial Chemosurgery."

"Rational Approach to the Development of Cosmetics—Their Effectiveness and Safety" will be the theme of the afternoon session at which Stephen Rothman, M. D., professor emeritus of dermatology at the Argonne Cancer Research Hospital of the University of Chicago, will preside.

Afternoon speakers will include: William M. Holliday, Ph. D., director of research for Chesebrough–Pond's Inc., Clinton, Conn., "Research and Development of Cosmetic Components and Formulation in Industry"; Rudolf L. Baer, M. D., professor and chairman of the department of dermatology, New York University School of Medicine, "Laboratory and Clinical Evaluations by Dermatologist—Effectiveness and Safety"; Arnold J. Lehman, M. D., director of the division of pharmacology of the Food and Drug Administration, Washington, D. C., "The Role of Government Regulatory Agencies"; Stockton Helffrich, (cq) manager of the New York office of the Code Authority of the National Association of Broadcasters, "The Responsibility of the Mass Media"; and Harold Aaron, M. D., medical advisor to the Consumer's Union, "Protecting the Consumer's Interest."

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SPECIAL PROGRAM HIGHLIGHTS
SUNDAY THROUGH WEDNESDAY

Air pollution and pulmonary disease
Viral hepatitis
Clinical nuclear medicine
Depression and suicide
Surgery—general, dermatologic, thoracic and neurologic
Cancer—etiology, pathogenesis, and chemotherapy
Orthopedics
Children's growth disturbances
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Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interests of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School. Books here listed will be available on loan from the Medical Library Service, S.M.I. Building, North Charter Street, Madison 6, Wisconsin.

NEW BOOKS RECEIVED

TOMORROW'S MIRACLE

A novel by Frank G. Slaughter, M. D. Doubleday and Company, Inc., Garden City, New York, 1962. 306 pages.

PRACTICAL ANESTHESIOLOGY

By Joseph F. Artusio, Jr., M. D., Professor of Anesthesiology in Surgery and Professor of Anesthesiology in Obstetrics and Gynecology, Cornell University Medical College, New York, N. Y.; Anesthesiologist-in-Chief, The New York Hospital–Cornell Medical Center, New York, N. Y.; and Valentino D. B. Mazzia, M. D., Professor and Chairman of the Department of Anesthesia, New York University School of Medicine and Postgraduate Medical School, New York, N. Y.; Visiting Physician in Charge of Anesthesia, University Hospital, New York, N. Y.; Chief Consultant in Anesthesiology, Manhattan Veterans Administration Hospital, New York, N. Y. The C. V. Mosby Company, St. Louis, 1962. 318 pages. Price: $7.75.

BEYOND TELEPATHY

By Andrija Puharich, M. D. Doubleday & Company, Inc., Garden City, New York, 1962. 312 pages. Price: $4.50.

TUMOUR VIRUSES OF MURINE ORIGIN

Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme, O. B. E., M. A., M. B., M. R. C. P., and Meave O'Connor, B. A., with 72 illustrations. Little, Brown and Company, Boston, 1962. 441 pages. Price: $10.75.

THORACIC AND CARDIOVASCULAR SURGERY WITH RELATED PATHOLOGY

By Gustaf E. Lindskog, B. S., M. A., M. D., F. A. C. S., William H. Carmalt Professor of Surgery, Yale University School of Medicine; Surgeon-in-Chief, University Service, Grace-New Haven Community Hospital; Averill A. Liebow, B. S., M. D., John Slade Ely Professor of Pathology, Yale University School of Medicine; Pathologist-in-Chief Grace-New Haven Community Hospital; and William W. L. Glenn, B. S., M. D., F. A. C. S., Professor of Surgery, Yale University School of Medicine; Chief, Section of Cardiovascular Surgery, Grace-New Haven Community Hospital. Appleton-Century-Crofts, New York, 1962. 1024 pages.

THE IMMUNOLOGY OF RHEUMATISM

By Jerzy B. Kwapinski, M. D., C. Sc., Head of the Subdepartment of Microbiology, University of New England, Australia, and Marshall L. Snyder, Ph. D., Professor of Bacteriology, The Dental School of The University of Oregon, Portland. Appleton-Century-Crofts, New York, 1962. 255 pages.

SYNOPSIS OF OBSTETRICS

Sixth edition, with 157 illustrations, including 4 in color. By Charles E. McLennan, M. D., Professor of Obstetrics and Gynecology, Stanford University School of Medicine, Palo Alto, Calif. The C. V. Mosby Company, St. Louis, 1962. 464 pages. Price: $6.75.

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County Society Proceedings

ASHLAND–BAYFIELD–IRON

The Ashland–Bayfield–Iron County Medical Society heard Dr. Robert Schilling of the University of Wisconsin Medical School speak on unusual blood diseases seen in private practice at their monthly meeting in October. Doctor Schilling's talk was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society.

BROWN

Dr. J. D. Kabler, University Hospitals, Madison, spoke on "Recognition and Control of Disabling Head Pains" at the November 8 meeting of the Brown County Medical Society held in St. Vincent's Hospital, Green Bay. Mr. John T. O'Hair of the Provident Life and Accident Insurance Company discussed the State Medical Society's disability program.

DANE

The program for the November 13 meeting of the Dane County Medical Society held at University Hospitals, Madison, included presentations on "Some Approaches to the Colon Cancer Problem," by *Dr. Robert O. Johnson* and *Dr. William H Wolberg*, both of Madison, and "Problems of the Student Health Clinic at a Large University," by *Dr. Peter L. Eichman*, director of the Student Health Clinic at the university.

DODGE

Dr. Harold Fromm, Madison, instructor in surgery at the University of Wisconsin Medical School, spoke on "Some Aspects of Colon Cancer" at the October meeting of the Dodge County Medical Society in Beaver Dam.

Doctor Fromm's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin division of the American Cancer Society.

GRANT

The Grant County Medical Society and the State Board of Health's Bureau for Handicapped Children sponsored a hearing conservation program in Cassville public and parochial schools in October.

KENOSHA

"Cardiac Resuscitation" was the subject under discussion at the November meeting of the Kenosha County Medical Society at the Elks Club, Kenosha.

MILWAUKEE

Fred H. Harrington, Madison, who recently took office as the 14th president of the University of Wisconsin, was the featured speaker at the 1962 annual meeting and election of officers of The Medical Society of Milwaukee County December 13 at the Wisconsin Club in Milwaukee. He spoke on "Our Plans and Problems at the University of Wisconsin."

Dr. Robert A. Frisch, Milwaukee was installed as president of the Society.

OZAUKEE

Dr. Meyer S. Fox, Milwaukee, assistant clinical professor of otolaryngology, Marquette University School of Medicine, spoke on "What the G. P. Should Know About Loss of Hearing" at the October meeting of the Ozaukee County Medical Society held in Grafton.

Doctor Fox's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from Merck Sharp & Dohme Postgraduate Program.

POLK

New officers of the Polk County Medical Society who were elected in October are:

President: *Dr. Donald Fink*, St. Croix Falls
Vice-president: *Dr. Lloyd L. Olson*, St. Croix Falls
Secretary-Treasurer: Doctor Olson
Delegate: *Dr. L. O. Simenstad*, Osceola
Alternate: *Dr. R. M. Moore*, Frederic

R. A. Frisch, M.D.

M. S. Fox, M.D.

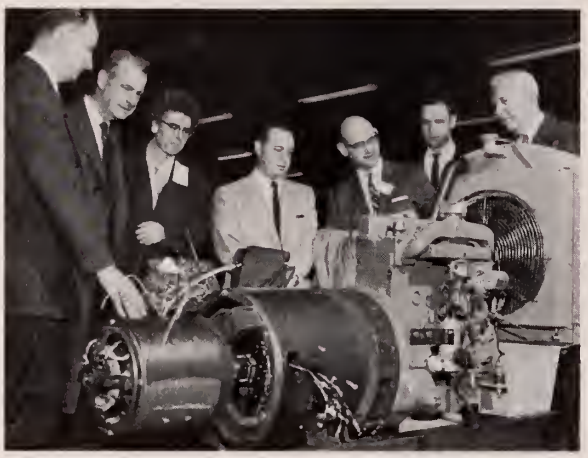
SAUK

A joint meeting of the Sauk County Medical Society and Sauk county nurses was held November 13 at Baraboo.

Physicians whose names appear in italic are members of the State Medical Society.

SHEBOYGAN

Touring the Kohler Company factories at Kohler November 15, members of the Sheboygan County Medical Society examined a Kohler electric plant of a type used for emergency power in hospitals and clinics. In the picture below are, from left: Don



Grzezinski of Kohler Company; *Dr. H. J. Hansen,* Sheboygan Falls; *Dr. Johanna Schlichting,* Sheboygan; *Dr. Donald M. Rowe* of Kohler Company; *Dr. J. S. Kretchmar,* Milwaukee; Lou Davit of Kohler Company; and *Dr. Harry H. Heiden,* Elkhart Lake. The factory tour preceded a dinner meeting of the Sheboygan County Medical Society in Kohler Company's American Club. Highlight of the meeting was an illustrated talk, "Don't Do It Yourself," by Doctor Kretchmar, a plastic surgeon who treats many injuries resulting from the indiscriminate use of power tools by home handymen. Approximately 40 physicians attended the meeting.

WASHINGTON

Members of the Washington County Medical Society heard *Dr. Robert O. Johnson,* Madison, speak on "Cancer of the Colon" at their October meeting held in Linden Inn at Big Cedar lake.

Doctor Johnson's appearance was sponsored by the Charitable, Educational and Scientific Foundation of the State Medical Society under a grant from the Wisconsin division of the American Cancer Society.

WINNEBAGO

The Winnebago County Medical Society met at the Athearn Hotel in Appleton November 1 to hear Dr. Harold Fromm, Madison, speak on "Cancer of the Colon."

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Specialty Society Proceedings

American Cancer Society
Wisconsin Division, Inc.

At the 1962 meeting of the American Cancer Society, Wisconsin Division, Inc., held at Wisconsin Rapids in October, *Dr. Gerhard I. Uhrich*, La Crosse, was elected to the executive committee and one of four to serve a three-year term as medical district director.

The 1962 Distinguished Service Award was preented to *Dr. Ralph C. Frank*, Eau Claire. *Dr. R. J. Samp*, Madison, moderated a symposium spotlighting dangers of juvenile smoking in which Arthur Mennes, Ph. D., Madison, and *Dr. Gail Williams*, Marshfield, participated.

American Psychiatric Association

The American Psychiatric Association has designated the Milwaukee county mental health center (south division) as a training center for "remotivation," a rehabilitation technique for mental patients. In the technique, a dozen or so regressed chronic mental patients are brought together for group discussion of topics of general interest. Purpose of the technique is to engage patients in human relationships, from which they have withdrawn, and stimulate them to return to reality.

The Milwaukee center is the 12th remotivation center set up by the Philadelphia State Hospital which has sent training teams to start centers throughout the country.

Wisconsin Heart Association
Rock County Unit

Dr. Marshall F. Purdy, Janesville, and *Dr. Robert L. Chancey*, Beloit, co-chairmen of the Rock County Unit of the Wisconsin Heart Association, planned an October meeting at Mercy Hospital in Janesville at which *Dr. George G. Rowe*, assistant professor of medicine at University Hospitals, Madison, instructed a group of Rock county physicians in the technique of external cardiac massage.

Milwaukee Oto-Ophthalmic Society

Programs and speakers for the 1962–1963 season have been announced by the Milwaukee Oto–Ophthalmic Society which meets monthly at the Milwaukee University Club. They include: "A New Approach to Cataract Extraction Following Filtering Surgery," by *Dr. Peter A. Duehr*, Madison, November; "Virus Diseases of the Eye," by Dr. Alson Braley, Iowa City, Ia., January; Dr. Bertha Kline, Chicago, Illinois, February; Dr. T. Manford McGee, Detroit, Michigan, March; cataract surgery films, April, and annual social meeting, May.

Milwaukee Academy of Medicine

Dr. Franz J. Ingelfinger, professor of internal medicine, Boston University School of Medicine, Boston, Mass., spoke on "Practical Diagnosis and Management of Malabsorption States" before the Milwaukee Academy of Medicine November 20 at the University Club of Milwaukee.

Dr. Eugene A. Stead, Jr., professor of medicine at Duke University School of Medicine, was the visiting professor and discussant of the clinical-pathological conference held in Milwaukee in connection with three days of medical sessions December 4 to 6. Subjects discussed were "Congestive Heart Failure," "Cardiac Function and the Peripheral Resistance," and "Control of Cardiac Performance."

Wisconsin Society of Pathologists

Recently elected officers of the Wisconsin Society of Pathologists are:

President—*Dr. David J. Carlson*, Milwaukee

President-elect—*Dr. Robert S. Haukohl*, Milwaukee

Vice-president—*Dr. Earnest Olson*, Racine

Secretary-Councilor—*Dr. David J. La Fond*, Milwaukee

Treasurer—*Dr. Chesley P. Erwin*, Milwaukee

Board of Censors—*Drs. Philip Piper*, Madison, chairman; *Joseph Lubitz*, Brookfield; *James Jaeck*, Sheboygan

Delegate to State Medical Society—*Dr. Joseph L. Teresi*, Brookfield

Alternate Delegate—*Dr. Lars Kleppe*, Beloit

Assemblyman—*Dr. Norbert Enzer*, Milwaukee

Wisconsin Dermatological Society

Newly elected officers of the Wisconsin Dermatological Society for 1962–1963 are as follows:

President: *Dr. Roger Laubenheimer*, Milwaukee

Vice-president: *Dr. Daniel E. Hackbarth*, Milwaukee

Secretary-treasurer: *Dr. Robert B. Pittelkow*, Milwaukee

Delegate: *Dr. J. E. Taxman*, Milwaukee

Alternate: *Dr. J. W. Bringe*, Sheboygan

Physicians whose names appear in italic are members of the State Medical Society.

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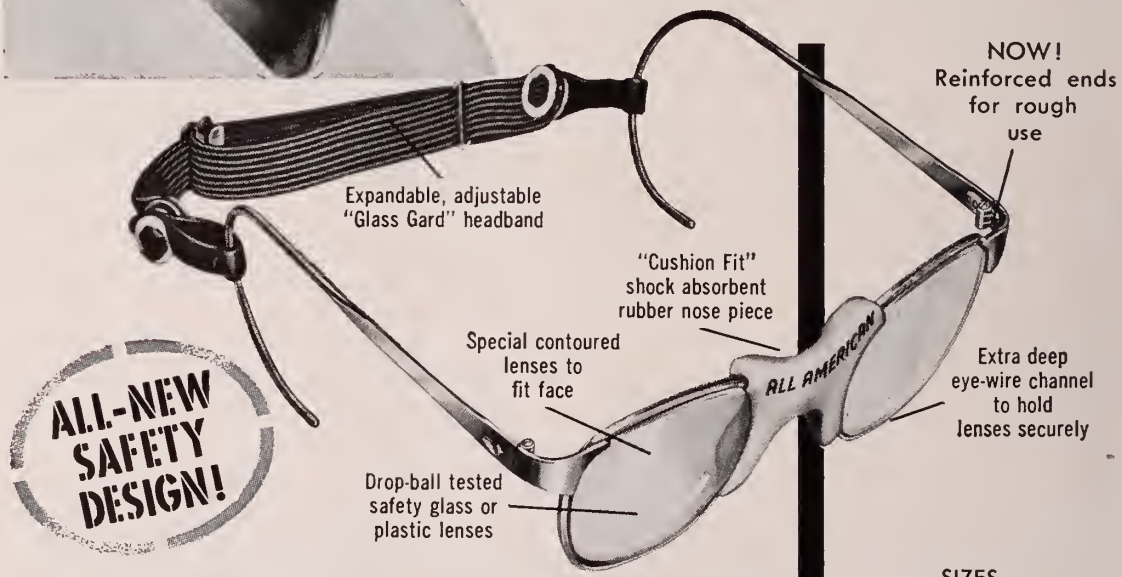

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News of Wisconsin Physicians

Former Students Honor Dr. Meyer

Forty-nine practicing physicians who received their training under *Dr. Ovid O. Meyer*, chairman of the University of Wisconsin Medical School department of medicine, honored him at a dinner at Chicago's Lake Shore Club November 2. They presented him with a silver tray inscribed with this tribute:

"To Ovid O. Meyer, M. D., friend and teacher of ours with great affection, we who were residents as students of medicine at the University of Wisconsin Hospital from 1944–62 have dedicated this gift. May this occasion be a happy one for you."

Some of the donors came from such distant points as Puerto Rico, Oregon, New York and Washington. *Dr. A. J. Richtsmeier*, Madison, organized the program and made the presentation.

Doctor Meyer put in his own internship and residency at Wisconsin, specializing in internal medicine. He joined the medical school faculty in 1932, and was appointed chairman in 1944. He has served as consultant to the U. S. Surgeon General since 1950 and to the Veterans Administration Hospital in Madison since 1958. His field of interest has centered in recent years on hematology.

Ovid O. Meyer, M.D.

L. G. Kindschi, M.D.

Dr. Kindschi Talks to Youth

Dr. Leslie Kindschi, Monroe, gave the keynote address at a College and Future Plans Night which was attended by about 250 persons from Monroe, Albany, Argyle, Juda, Monticello, and New Glarus. It was held at the Monroe high school late in October.

Doctor Kindschi told the young people not to settle for the type of work that will soon be done by a machine but rather to train themselves to master the machine that will do the ordinary tasks. In this way, they will assure themselves of future employment and the benefits that steady employment brings, he said.

Dr. Galasinski Honored in Milwaukee

Dr. Roman E. Galasinski, Milwaukee, was honored with a citation for his humanitarian services, devotion to the medical profession, and leadership in civic and charitable organizations at the Milwaukee Society Pulaski Day dinner in Millwaukee October 20.

Becomes Diplomate in Dermatology

Dr. Robert R. Baumann, Monroe Clinic dermatologist, has been certified a diplomate of the American Board of Dermatology.

Doctor Baumann received his medical degree in 1954 from Johns Hopkins University in Baltimore and then served four and one-half years in the Air Force medical service. His special training included three years at the Hitchcock Clinic and Dartmouth Medical College at Hanover, N. H. He joined The Monroe Clinic staff in the spring of 1961, and he also is an instructor of dermatology at the University of Wisconsin Medical School.

Dr. Batzner Opens Sheboygan Office

Dr. David J. Batzner has returned to his home town of Sheboygan to establish a medical practice there. He will specialize in obstetrics and gynecology.

Doctor Batzner received his B. S. degree from the University of Wisconsin and his M. D. degree from Marquette University School of Medicine. He interned at Misericordia Hospital, Milwaukee, and had three years of residency in obstetrics and gynecology at St. Joseph's Hospital, Milwaukee, before entering private practice in Waukesha where he has made his home for the past two years. He served as clinical instructor at Marquette University School of Medicine before moving to Sheboygan.

He has written several articles relating to obstetrical anesthesia which have been published nationally and he also has been a lecturer and educational advisor to the Natural Childbirth Association.

Dr. Nevin Speaks Before Hospital Auxiliary

Dr. I. Nik Nevin, Rhinelander, was the guest speaker at the October meeting of the Eagle River Memorial Hospital auxiliary. Doctor Nevin, who is a radiologist at St. Mary's Hospital in Rhinelander and at the Eagle River hospital, talked on "The Use of X-ray in Medicine."

Dr. Querol Moves to Appleton

Dr. J. T. Querol and his family, who have lived in Black Creek since 1960, have moved to Appleton

Physicians whose names appear in italic are members of the State Medical Society.

WISCONSIN PHYSICIANS *continued*

where Doctor Querol is specializing in the practice of urology. His offices are in The Zuelke Building.

Dr. Murphy Joins La Crosse Clinic

Dr. James Murphy, native of Fargo, N. D., has joined the La Crosse Clinic at La Crosse. Doctor Murphy took his surgical residency at Milwaukee County Hospital after serving two years with the Air Force in Japan as a medical officer. He did his undergraduate work at the University of Notre Dame and received his M. D. degree from the University of Maryland.

James Murphy, M.D.

Thorn L. Vogel, M.D.

Dr. Vogel Takes Janesville Post

Dr. Thorn L. Vogel has been named city health officer for Janesville. Doctor Vogel, who practiced medicine in Milton Junction for 31 years before he moved away two years ago, has been a public health physician with the bureau of maternal and child health in the city of Milwaukee.

Dr. Smiley Attends National Conference

Dr. Glenn Smiley, Delavan, attended the national meeting of the American Cancer Society in New York in October. He is the national delegate and vice-president of the Wisconsin Division and president of the Walworth unit.

Dr. Vedder Serves with Project Hope

Dr. James S. Vedder of the Marshfield Clinic finished an eight-week tour of duty early in December with Project Hope in South America.

Doctor Vedder, who volunteered for the Project Hope duty through the private medical agency, The People to People Health Foundation, Inc., served as a member of the pediatrics staff of the University of Trujillo, which is 350 miles north of Lima, Peru. Although the university is more than 300 years old, the medical school is only five years old and the pediatric ward has been in existence scarcely more than a year.

The goal set for the team of 19 medical men, composed of physicians drawn from every corner of the United States, is a teaching program for the university which will help make it Peru's outstanding medical school.

Responsibilities of the pediatric section with which Doctor Vedder was occupied fell in three areas: aboard ship; in Belen Hospital, which is the teaching hospital of the university; and in the barriadas or slum areas surrounding Trujillo.

The rotating medical staff of Project Hope supplements a permanent staff of medical personnel. The "rotators" are volunteers who leave their families, homes, incomes, and practices to spend several months teaching as well as learning.

Dr. Lanier on National Commiltee

Dr. Patricia Lanier, Kewaunee, traveled to Washington, D. C., in October to attend a meeting of the national committee on social and economic issues of the American Association of University Women. Doctor Lanier is one of six women from various parts of the United States who are serving on the committee which, among other things, is studying food additives and chemical tolerances.

Dr. Sender Elected Junior Fellow

Dr. Neville Sender, Milwaukee, has been elected a junior fellow of the American College of Obstetricians and Gynecologists.

Physicians Certified by Psychiatry Board

Two Sheboygan psychiatrists recently passed their board examinations and are now certified by the American Board of Psychiatry and Neurology, Inc. They are *Dr. Francis L. Mooney* and *Dr. E. H. Jochimsen.* Doctor Mooney is associated with Dr. Edward Houfek in psychiatric practice and Doctor Jochimsen is on the staff of the Sheboygan Clinic.

Elected Fellow in Clinical Hypnosis Group

Dr. Austin J. McSweeny, who practices his specialty of internal medicine and psychotherapy in Janesville, has been elected a fellow of the American Society of Clinical Hypnosis following two years of associate membership.

Dr. Engel Addresses Kiwanians

"Climatic Environment in Health and Disease" was the topic which *Dr. A. C. Engel* discussed before the New Holstein Kiwanians late in October.

Dr. Hoessel Moderates Lectures

Dr. A. W. Hoessel, Wausau, was a moderator for the regional conference on "Strokes—What Can We Do About Them" which was held in Wausau October 24. The conference, which was part of the State Medical Society teaching program, was sponsored by the Wisconsin Academy of General Practice, Wisconsin Board of Health and the Merck Sharp & Dohme Postgraduate Program.

BONADOXIN®
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Confirmed in over 7 years of clinical success: Bonadoxin stops morning sickness in 9 out of 10 patients[1]

Highly effective in other emetic conditions: postoperatively, following irradiation procedures, infant colic.

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time-tested for efficacy and safety

1. Groskloss, H.H., Clancy, C.L., Healey, E.F., McCann, W.J., Maloney, F.D., Loritz, A.F.: Clinical Medicine (Sept.) 1955.

Study involving 287 patients. 261 patients experienced excellent to good results with Bonadoxin for relief of nausea and vomiting of pregnancy. No side effects reported.[1]

2. Albertson, H.A., Trout, Jr., H.H., Daily, F.W.: The American Journal of Surgery (Sept.) 1956.

"As a result of this study, it is our belief that the routine prophylactic use of the combination of meclizine hydrochloride and pyridoxine is a safe and effective method for lessening the incidence of postoperative nausea and vomiting. We are employing this preparation as a routine pre-operative medication."[2]

3. Goldsmith, J.W.: Minn. Med. (Feb.) 1957.

Study involving 620 patients, 537 patients experienced moderate to complete improvement of nausea and vomiting of pregnancy with Bonadoxin. Toxicity and intolerance to the medication in the dosage employed in these studies was zero.[3]

4. Codling, J.W.; Lowden, R.J.: Northwest Med. (March) 1958.

Study involving 76 pregnant patients with nausea and vomiting. The results indicated an overall response in 70 of 76 patients treated. No side reactions were observed in this clinical study.[4]

5. Bentley, M.D.: Journal of the Mich. State Med. Soc. (Sept.) 1959.

[Bonadoxin] "was found clinically effective in the prevention of pre-operative and post-operative nausea and emesis in 157 patients who underwent ocular surgery, while control drugs alone could not completely eliminate the symptoms. Bonadoxin did not cause side reactions in the preoperative or postoperative phase of this study."[5]

6. Bethea, R.C.: International Record of Med. (May) 1960.

"Our investigation of this drug indicates that in 88 per cent of the cases satisfactory relief of the distressing symptoms of early pregnancy was obtained without undesirable side effects, including sedation."[6]

7. Sklaroff, D.M.; Karayannis, N.: Current Therapeutic Research (June) 1962.

"Based on these results, indicating 92 per cent effectiveness, meclizine-pyridoxine (Bonadoxin®) may be considered a valuable compound in the control of post-irradiation nausea and vomiting. The preparation proved to be safe and fast-acting in bringing therapeutic relief to carcinoma patients with radiation sickness."[7]

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Dr. Gene Krohn Returns to Clinic

Dr. Gene Krohn, who was stationed at the base hospital at Portsmouth, New Hampshire, has resumed his position on the staff of the Krohn Clinic and Hospital which was founded by his grandfather, the late Dr. Eugene Krohn, his father, *Dr. Robert Krohn*, and his uncle, the late Dr. John Krohn.

Doctor Gene Krohn took his premedical work at Lawrence College at Appleton and received his M. D. degree from the University of Wisconsin. He interned at the Denver, Colorado County and City Hospital a year. He was stationed at the Air Force Base Hospital at Osan, Korea, for 13 months and later at Portsmouth for 9 months. He received a special commendation medal for meritorious service at the Korean hospital.

Dr. Cummings Speaks to Engineers

"Internal Hydraulics" was the topic on which *Dr. Earl F. Cummings*, Oshkosh, spoke at a meeting of the Fox River Valley chapter of the Wisconsin Society of Professional Engineers in Oshkosh in October.

E. F. Cummings, M.D.

P. B. Mason, M.D.

Dr. Mason Returns from Boston

Dr. P. B. Mason, Sheboygan, traveled to Boston, Mass., late in October to participate in a postgraduate course devoted to rheumatic diseases, their pathology, diagnosis, and treatment. The course was sponsored by the Harvard University Medical School and the American College of Physicians.

Dr. Lanier Talks on Diabetes

Dr. Patricia Lanier, Kewaunee, discussed treatment and complications of diabetes and diabetes in children in the second of a four-series program on diabetic education planned for registered and licensed practical nurses of Door and Kewaunee counties.

Visiting Anesthesiologist in Door County

Dr. H. R. Peters, who was on the Door county medical staff for several years before he left to study anesthesiology, is returning to Sturgeon Bay in Door county one day each month to administer anesthesia and to instruct the nurse anesthetists at the hospital. At present he is a member of Rockford Memorial Hospital staff and a clinical instructor at Marquette University School of Medicine in Milwaukee.

State OB Specialists at District Meeting

Several Wisconsin physicians participated in the annual meeting of District VI of the American College of Obstetricians and Gynecologists held at Minneapolis, Minn., October 18 to 21. *Dr. William Luetke*, Madison, was a member of the program committee. *Dr. Ben M. Peckham*, Madison, is chairman of the Wisconsin section and *Dr. Alex Krembs*, Milwaukee, is vice-chairman. *Dr. John W. Bunke*, Milwaukee, is secretary-elect of the District VI Junior Fellow division.

Program speakers included Drs. Bunke, Dorothy M. Barbo, Roland A. Pattillo, *Alvin M. Kurzon* and Richard F. Mattingly, all of Milwaukee; Doctor Luetke, Madison; *Dr. R. C. Brown*, Eau Claire; and *Drs. John G. Webster* and Carl Kobelt, Manitowoc.

Dr. Mirhoseini Joins Hospital Staff

Dr. Mahmood Mirhoseini, a native of Iran who established a medical practice in Athens a few months ago, has joined the medical staff at Memorial Hospital of Taylor County.

Sheboygan Physicians Speak to Auxiliaries

Dr. J. D. Michael, Sheboygan, was the guest speaker at the St. Nicholas Hospital auxiliary meeting in Sheboygan October 16. *Dr. E. H. Jochimsen*, Sheboygan, spoke at the semi-annual meeting of the Memorial Auxiliary of Sheboygan Memorial Hospital on November 2.

Dr. Schwade Elected to Office

Dr. Leonard J. Schwade, Milwaukee, is a newly-elected governor in the American College of Gastroenterology.

Dr. Snodgrass Speaks at Workshop

"Improving the Public Image of Nursing Homes" was the theme of the workshop of District 1, Wisconsin Association of Nursing Homes, in which *Dr. Herbert Snodgrass*, Janesville, participated. It took place in Janesville in October.

Dr. Cantwell Serves in Hospital Campaign

Dr. Roger C. Cantwell, Shawano, is chairman of the medical gifts division of the Shawano Community Hospital Building Fund Campaign. The hospital, which serves the Shawano–Menominee County area, has received a $240,000 outright Fed-

eral Hill–Burton grant toward the $600,000 expansion program costs.

Johns Hopkins Alumni to Visit Schools

Two Madison physicians, both of whom are graduates of Johns Hopkins University, have been appointed representatives of the Johns Hopkins University national alumni schools committee and will visit high schools in Madison. They are *Dr. Albert V. Kanner* and Albert Marston, Ph. D., of the University of Wisconsin department of psychology.

Dr. Hoon Holds Office in Cancer Society

Dr. J. R. Hoon, Sheboygan, has been reelected to the executive board of the Wisconsin division of the American Cancer Society.

Doctor Hoon attended the conference of the American College of Surgeons in New York October 19 to 27.

Dr. Braun Speaks on Africa

Dr. N. P. Braun, Sheboygan, addressed the wives of the personnel at the Wisconsin Public Service Corporation on "Africa" October 29.

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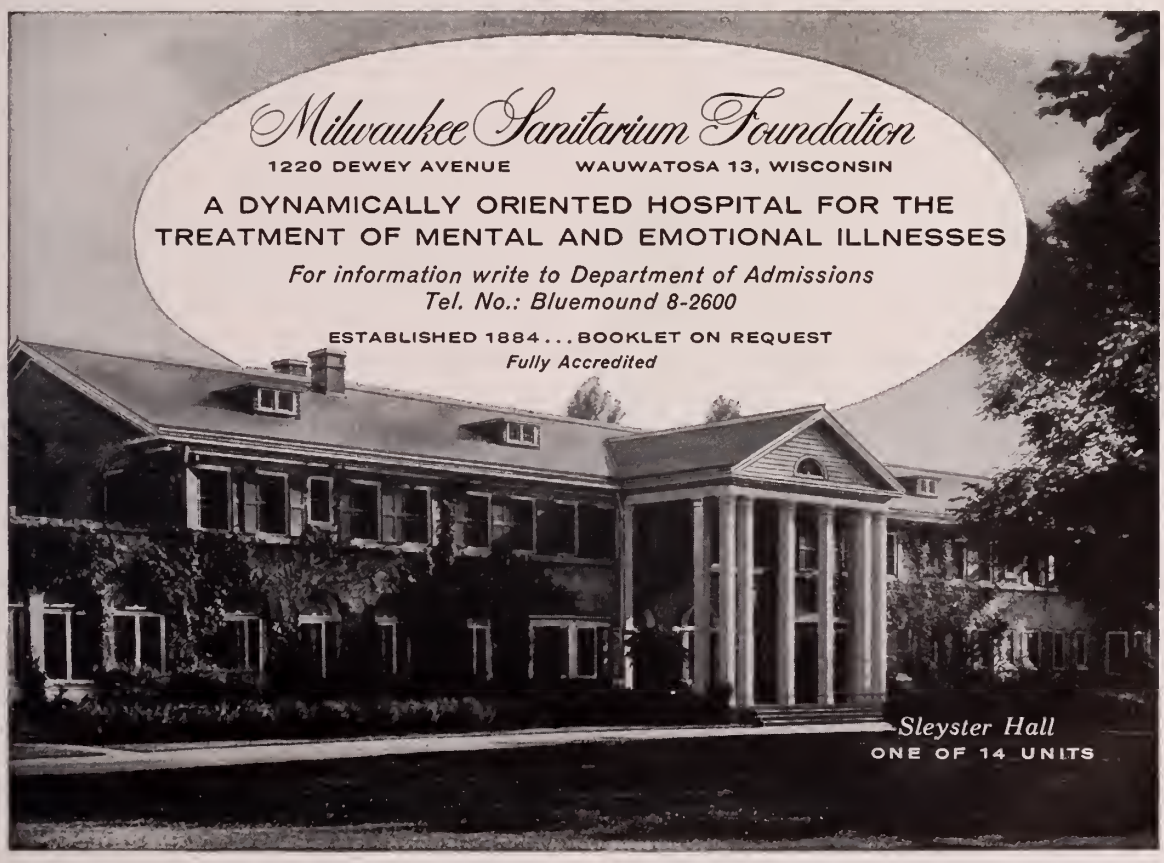

WISCONSIN PHYSICIANS *continued*

Dr. Reinke Honored for Service

Dr. Christoph C. Reinke, Milwaukee, received a plaque "commemorating his 40 years of devoted service to South Division and his athletes" early in November at South Division high school's athletic honor day in Milwaukee. Doctor Reinke, who is 70, has been team physician for the high school ever since he established practice on the south side of Milwaukee in 1923. A former South Division athlete himself, Doctor Reinke was quarterback on three city championship teams in 1910, 1911 and 1912.

Dr. Hirschboeck Predicts Cancer Solution

Speaking to 50 business and industry representatives from five midwest states who met in Milwaukee recently to study the problem of private support for cancer research, *Dr. John S. Hirschboeck*, dean of Marquette University School of Medicine, stated that the solution to the cancer problem "could reasonably be predicted during the next decade." He pointed to the unusual developments in research, particularly in the field of biology, and compared the hopes of 10 years ago to the discoveries of today.

Dr. Hans Reese (right), emeritus professor of neurology at the University of Wisconsin, received the Officer's Cross of Merit from Dr. Gunther C. Motz, Chicago, consul generol of the Federol Republic of Germany. According to Prof. Chester Easum of the University of Wisconsin history deportment, on expert on Germon offoirs, the Germon people feel the Cross of Merit is one of the most distinguished owords mode by the republic.

Dr. Reese Receives German Cross of Merit

Dr. Hans Reese, emeritus professor of neurology at the University of Wisconsin, received the Officer's Cross of Merit from Dr. Gunther C. Motz, Chicago, consul general of the Federal Republic of Germany, at a medical faculty convocation in Madison in November.

The award from the German government was made to Doctor Reese in recognition of his distinguished career as a scientist and for his activity in German-American relations. Born in Germany, Doctor Reese came to America to become a citizen after completing his medical studies in Germany. He was a member of the University of Wisconsin Medical School faculty for 37 years before retiring last June.

Sacred Heart Hospital Elects Officers

Dr. R. J. Fink has been reelected president of the medical staff of Sacred Heart Hospital at Eau Claire. Other newly elected officers are: *Dr. T. E. Kilkenny*, vice-president; *Dr. G. D. McAfee*, secretary-treasurer; *Dr. A. J. Klein*, chief of services of medical staff; *Dr. Karl Walter*, chief of services of the obstetrics and gynecology departments; *Dr. K. L. German*, chief of services for surgery.

Dr. Eckstam Gives Training Course

Dr. Eugene E. Eckstam, Monroe, gave first aid instruction in mouth-to-mouth resuscitation and closed chest heart massage to district supervisory employees of the Wisconsin Power and Light Company at the Mineral Point district office early in November. He conducted the course under the sponsorship of the Wisconsin Heart Association in cooperation with the Wisconsin Power and Light Company's safety department.

Dr. Ashe Attends Postgraduate Course

Dr. Henry S. Ashe, Minocqua, attended a postgraduate course in orthopedic surgery which was presented under the direction of the Chicago Medical Society in November.

Dr. Frank Talks at Bloomer

Dr. Ralph Frank, Eau Claire radiologist, spoke on the importance of x-rays and the role of a radiologist in a hospital at the annual meeting of the Bloomer Community Memorial Hospital at Bloomer in November.

Dr. Tenney Gives Talks

Dr. H. Kent Tenney, Madison, was the guest speaker at the November luncheon of the Intermediate Women's Club at Beloit November 1.

On November 8, Doctor Tenney spoke on "Community Action for Mental Health" at the second annual meeting of the Iowa county Mental Health Association held in Mineral Point.

Dr. Van Valin Is Made Honorary Fireman

Dr. E. C. Van Valin, Sussex, was made an honorary fireman when the volunteer firefighters who have made up the Sussex fire department for the past 40 years held an anniversary party recently. For assisting with emergency calls, Doctor Van Valin was presented a plaque which read: "For faithful service—40 years to the Sussex Fire Department."

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1 Ford, R. A., and Blanchard, K. Journal Lancet 78:185, 1958

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WISCONSIN PHYSICIANS *continued*

Physicians Hold New Clinic Open House

Dr. C. L. Steidinger and *Dr. M. F. Stuessy* held an open house recently in the new quarters of the Steidinger Clinic in Platteville.

Dr. McGinnis Heads County Heart Unit

Dr. James P. McGinnis, Superior, has been named chairman of the Douglas County unit of the Wisconsin Heart Association.

Welfare Council Reelects Dr. Parks

Dr. H. K. Parks, Madison, has been reelected president of the Madison Jewish Welfare Council which is the central planning agency for the Jewish community of Madison.

Dr. Russell Attends Conference on Sports

Dr. James Russell, Fort Atkinson, attended the 4th National Conference on Medical Aspects of Sports in Los Angeles, November 25.

Dr. Leland Pamoinville (right), accepted the Reuben Gold Thwaites trophy for the South Wood County Historical Corporation of which he is president. Prof. William B. Hesseltine (left), president of the State Historical Society, made the presentation at an awards banquet in Madisan.

Dr. Pomainville Accepts Trophy

The Reuben Gold Thwaites trophy, presented annually by the State Historical Society to the outstanding local historical society in Wisconsin, was presented to *Dr. Leland Pomainville,* Wisconsin Rapids, at an awards banquet held in Madison recently.

Doctor Pomainville, accepted the award on behalf of the South Wood County Historical Corporation, of which he is president. The South Wood County group was cited for its promotion of local history in its area and especially in the schools.

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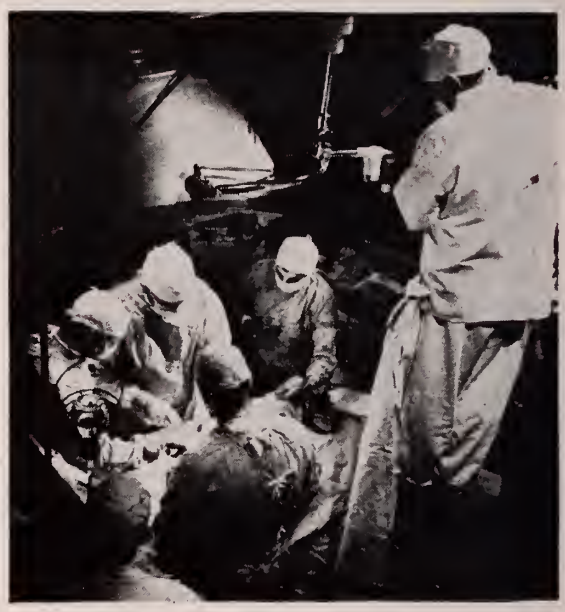

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Society Records

MEMBERSHIP REPORT AS OF OCTOBER 31, 1962

NEW MEMBERS

Allen G. Brailey, Jr., 1836 South Avenue, La Crosse.

Martin E. Farbstein, Hazel Green Clinic, Hazel Green.

A. A. Koeller, 206 6th Avenue West, Ashland.

Stanley Miezio, Jr., Department of Psychiatry, 1300 University Avenue, Madison 6.

Donald M. Nowinski, 120 Clarke Street, Wausau.

Leif O. Torkelson, 2 West Gorham Street, Madison 3.

Ronald L. Uecker, Wausau Memorial Hospital, Wausau.

CHANGES OF ADDRESS

Paul E. Aszman, Florida, to % Mr. William Sharks, Route 2, Portage.

Jay P. Bartlett, Milwaukee, to 3912 Grove Street, Palo Alto, Calif.

William A. Brah, 10425 North 104th Street, Wauwatosa.

Robert G. Brault, 6186 Washington Circle, Wauwatosa.

J. G. Brown, Cambria, to 812 Owen Road, Madison.

William M. Brown, Jr., Milwaukee, to Los Angeles City Health Department, 1200 Armada Drive, Pasadena, Calif.

Albert M. Cohen, Milwaukee, to V. A. Hospital, Wood.

Donald P. Davis, Erie, Pennsylvania, to 2538 Kent Street, Sunset Hills Subdivision, Topeka, Kan.

Loren J. Driscoll, 34810 Pabst Road, Oconomowoc.

Harold J. Dvorak, Milwaukee, to Vanderbilt Hall, Harvard Medical School, Boston 15, Mass.

Richard L. Fodor, Milwaukee, to 25830 Yoeman Drive, Westlake, O.

Salvatore Fricano, Wood, to 5810 West Oklahoma Avenue, Milwaukee.

R. J. Gardner, Chicago, Illinois, to 712–15th Street, Menomonie.

Paul R. Glunz, Marshfield, to 12714 Gould Road, Wheaton, Md.

Stanley L. Grosshandler, Milwaukee, to 5861 Fulham Court, Greendale.

John W. Harkness, Wauwatosa, to Peace Corps, % American Embassy, A.P.O. 928, San Francisco, Calif.

Beryl A. Harris, Minneapolis, Minnesota, to 3975 North 68th Street, Milwaukee.

W. F. Henken, 500 Walton Avenue, Racine.

E. T. Hougen, Sheboygan, to 10339 Zelzah Avenue, Apt. 29, Northridge, Calif.

E. E. Kern, 314 Main Street, Mukwonago.

*Marvin M. Kirchner, San Francisco, to U. S. Army Hospital, Fort Jackson, S. C.

A. M. Kowalski, Topeka, Kan. to 777 Mulberry, Atwater, Calif.

Willard A. Krehl, Milwaukee, to University of Iowa Medical School, Iowa City, Ia.

James M. Lee, Milwaukee, to V. A. Hospital, Long Beach, Calif.

Leo M. Lifschutz, 807 16th Street, Racine.

*John P. Locksmith, 832 T.A.C. Hospital, Clovis, N. M.

R. L. MacCornack, Sr., Whitehall, to 1629 West Osborn Road, Phoenix 15, Ariz.

Earl W. Martens, 10425 North 104th Street, Wauwatosa.

*T. J. Martens, Monterey, to 311 Arlon Court, Fort Ord, Calif.

Elton Mendeloff, 10425 North 104th Street, Wauwatosa.

M. H. Miller, 3682 Lake Mendota Drive, Madison 5.

*G. T. Mohler, Fort Lewis, to 8606 South Ainsworth, Tacoma, Wash.

Arche Pequet, 10425 North 104th Street, Wauwatosa.

Samuel G. Perlson, 425 East Wisconsin Avenue, Milwaukee.

B. H. Roisum, 222 North Midvale Boulevard, Madison 5.

W. E. Rosenkranz, 720 North Rochester, Mukwonago.

Charles C. Smith, Oak Park, Illinois, to 2707 Ravine Way, Green Bay.

Jack D. Spankus, 2040 West Wisconsin Avenue, Milwaukee.

Gerald O. Stubenrauch, Greendale, to 8410 West Cleveland Avenue, West Allis 19.

Benjamin Wein, 7121 West Appleton Avenue, Milwaukee.

E. E. Zwisler, 720 North Rochester, Mukwonago.

* Military member.

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CALENDAR OF MEETINGS

1963 **Wisconsin**

Jan. 10: Postgraduate course on Some Common Dermatologic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Jan. 16: SMS Maternal mortality institute, St. Catherine's Hospital, Kenosha (AAGP credit).

Feb. 6: SMS postgraduate course on Clinical Electrocardiography (Dr. Richard Wasserburger), St. Luke's Hospital, Racine (AAGP credit).

Feb. 7: Postgraduate course on Topics of Current Interest in the Care of the Newborn, University of Wisconsin Medical Center, Madison.

Feb. 13–14: Postgraduate course on Recent Advances in Gynecology and Obstetrics, Marquette University School of Medicine, Milwaukee.

Feb. 26: SMS circuit teaching program (surgery: Dr. G. E. Collentine; medicine: Dr. Burton Waisbren; pediatrics: Dr. Gerald Kerrigan), St. Vincent's Hospital, Green Bay (AAGP credit).

Feb. 27: SMS circuit teaching program (same as above), Langlade County Memorial Hospital, Antigo (AAGP credit).

Mar. 7: Postgraduate course on Some Orthopedic Problems Occurring in General Practice, University of Wisconsin Medical Center, Madison.

Mar. 7–9: Postgraduate course on The Hemiplegic Patient, University of Wisconsin Medical Center, Madison.

Mar. 21–23: Postgraduate course on Advances in Immunology and Hypersensitivity, University of Wisconsin Medical Center, Madison.

April 18–19: Annual meeting, Wisconsin Anti-Tuberculosis Association, Pfister Hotel, Milwaukee.

April 25–27: Postgraduate course on Renal Diseases in Childhood, University of Wisconsin Medical Center, Madison.

May 6–9: State Medical Society of Wisconsin annual meeting, Milwaukee Auditorium and Hotel Schroeder, Milwaukee.

1963 **Out-of-State**

Jan. 16–18: American Diabetes Association Postgraduate course on Diabetes in Review: Clinical Conference, 1963, Boston.

Jan. 21–25: Postgraduate course on Blood Vessels and Problems of Thromboembolism—Diagnosis and Treatment, American College of Physicians, Cornell University Medical College and the New York Hospital, New York.

Jan. 24–26: Symposium on Genetics and Heart Disease, Heart Association of Southeastern Pennsylvania, Hotel Sheraton, Philadelphia.

Jan. 28–30: 27th annual session of the International Medical Assembly of Southwest Texas, Granada Hotel, San Antonio, Tex.

Feb. 11–15: Postgraduate course on Modern Physiological Concepts of Cardiovascular Disease, Presbyterian Medical Center, American College of Physicians, Presbyterian Medical Center, San Francisco, Calif.

Mar. 4–6: Meeting of Canadian-American Medical and Dental Ski Association, Iroquois Mountain, Brimley, Mich.

Mar. 4–8: Postgraduate course on Physical Methodology in Medical Research, Massachusetts Institute of Technology, American College of Physicians, Massachusetts Institute of Technology, Cambridge, Mass.

Mar. 8–9: AMA Medicolegal Symposium, Americana Hotel, Miami Beach, Florida.

Mar. 18–23: Postgraduate course on Recent Advances in Cardiovascular Disease, American College of Physicians, The Mount Sinai Hospital, New York.

Mar. 24–29: American College of Allergists Graduate Instructional Course and Nineteenth Annual Congress, Americana of New York, New York City.

Mar. 25–29: American Society of Anesthesiologists Biennial Western Conference on Anesthesiology, Hawaiian Village, Honolulu.

June 10–13: Convention of the Catholic Hospital Association of the United States and Canada, Conrad Hilton Hotel, Chicago.

Nov. 5–13: Ninth Congress of the Pan-Pacific Surgical Association, Honolulu, Hawaii.

Nov. 13–Dec. 10: First Pan-Pacific Mobile Educational Lecture Seminar, New Zealand, Australia, Thailand, the Philippines, Hong Kong and Japan.

Medical Meetings

Postgraduate Courses

University of Wisconsin Postgraduate Course

The Department of Pediatrics of the University of Wisconsin will hold a two and one-half day postgraduate seminar on "Renal Diseases in Childhood" April 25–27, 1963. The diagnosis and management of congenital and acquired conditions including pyelonephritis, glomerulonephritis, nephrosis, and tubular disorders will be discussed following basic orientation in renal structure and function. Special attention will be paid to the developmental aspects of renal function. Cases will be presented and ample time and facility allowed for close contact of faculty and registrants.

The faculty will include: Dr. W. W. McCrory, professor and chairman, department of pediatrics, Cornell University; Dr. Robert A. Good, professor of pediatrics, University of Minnesota; Dr. Malcolm A. Holliday, associate professor of pediatrics, University of Pittsburg; Dr. Robert W. Winters, associate professor of pediatrics, Columbia University; and Dr. Edward H. Kass, associate professor of bacteriology and immunology, Harvard Medical School; and members of the pediatric department of the University of Wisconsin.

Detailed programs and registration forms are available from the Coordinator of Postgraduate Medical Education, The Wisconsin Center 702 Langdon Street, Madison, Wisconsin.

American Diabetes Association

The American Diabetes Association will hold its eleventh postgraduate course, "Diabetes in Review: Clinical Conference, 1963," in Boston, Mass., January 16, 17 and 18.

The American Academy of General Practice will give 18 hours of Category II credit for the course. The three-day course is open to doctors of medicine and the fee is $40 for members of the American Diabetes Association; $75 for nonmembers.

Additional information may be secured from the American Diabetes Association, 1 East 45th Street, New York 17, New York.

Heart Association of Southeastern Pennsylvania

A two and one-half day symposium on "Genetics and Heart Disease" will be sponsored by the Heart Association of Southeastern Pennsylvania at the Hotel Sheraton, Philadelphia, January 24–26, 1963.

For a copy of the program and an advance registration application form, write: Albert N. Brest, M. D., Heart Association of Southeastern Pennsylvania, 318 South 19th Street, Philadelphia 3, Pa.

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Henry J. Tumen, M. D., Philadelphia, Pa.
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Logan T. Robertson, M. D., Asheville, N. C.
GENERAL PRACTICE
Andrew A. Marchetti, M. D., Washington, D. C.
GYNECOLOGY
Raymond D. Pruitt, M. D., Houston, Texas
INTERNAL MEDICINE
Paul S. Rhoads, M. D., Chicago, Ill.
INTERNAL MEDICINE
C. H. Hardin Branch, M. D., Salt Lake City, Utah
NEUROPSYCHIATRY
J. Robert Willson, M. D., Philadelphia, Pa.
OBSTETRICS
James I. Moore, M. D., Baltimore, Md.
OPHTHALMOLOGY
James E. Bateman, M. D., Toronto, Ont., Can.
ORTHOPEDIC SURGERY
Joseph H. Ogura, M. D., St. Louis, Mo.
OTOLARYNGOLOGY
Edward A. Gall, M. D., Cincinnati, Ohio
PATHOLOGY
Weston M. Kelsey, M. D., Winston-Salem, N. C.
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Curtice Rosser, M. D., Dallas, Texas
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John L. Keeley, M. D., Chicago, Ill.
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MEDICAL MEETINGS *continued*

Registration deadline is January 11, 1963. Registration fee is $20.

International Medical Assembly of Southwest Texas

The 27th annual session of the International Medical Assembly of Southwest Texas will be held in San Antonio, Tex., January 28–30, 1963, at the Granada Hotel. Among the speakers will be Dr. Fred J. Ansfield, Madison. The program will be a symposium concerning all aspects of cancer.

Marquette University Postgraduate Course

The Marquette University School of Medicine in cooperation with the Milwaukee County Hospital will offer a postgraduate course in "Gynecology and Obstetrics" Feb. 7, 8 and 9, 1963, in the Coffey Memorial Auditorium of the Milwaukee County Hospital, 8700 W. Wisconsin Ave., Milwaukee.

Sessions will be: Thursday, Feb. 7, 12:45 p.m. to 4:30 p.m.; Friday, Feb. 8, 8:30 a.m. to 5:30 p.m., and Saturday, Feb. 9, 9 a.m. to 12:30 p.m.

Guest speakers will be Dr. R. W. TeLinde, professor emeritus, department of gynecology, Johns Hopkins University School of Medicine, Baltimore, Md., and Dr. N. J. Eastman, professor emeritus, department of obstetrics, Johns Hopkins University School of Medicine, Baltimore, Md., and professor and acting head, department of obstetrics and gynecology, The University of Minnesota Medical School, Minneapolis, Minn. Doctor Eastman's appearance will be supported by a grant from the Merck Sharp and Dohme Postgraduate Program.

Dr. Richard F. Mattingly, professor and chairman, department of gynecology and obstetrics, Marquette University School of Medicine, is director of the course.

Reservations may be made with Joseph W. Rastetter, M.D., Director, Postgraduate Medical Education Programs, 8700 W. Wisconsin Ave., Milwaukee 13, Wis.

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PROCTOSCOPY & SIGMOIDOSCOPY, One Week, Dec. 17, Jan. 28
VARICOSE VEINS, One Week, Dec. 17, Jan. 28
GENERAL SURGERY, One Week, February 25
BOARD OF SURGERY REVIEW, Part II, Two Weeks, March 4
BASIC INTERNAL MEDICINE, Two Weeks, March 4
MANAGEMENT OF COMMON FRACTURES & DISLOCATIONS, One Week, Dec. 3, Feb. 25
BOARD OF INTERNAL MEDICINE REVIEW, Part II, One Week, April 8
GALLBLADDER SURGERY, Three Days, March 11
SURGERY OF HERNIA, Three Days, March 14
CLINICAL COURSES IN FRACTURES, DERMATOLOGY, PEDIATRICS, RADIOLOGY, by appointment.
ELECTROCARDIOGRAPHY, One Week, March 18
BASIC PRINCIPLES IN GENERAL SURGERY, Two Weeks, March 18

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FASTER DEPRECIATION SCHEDULES being readied by the Treasury Department should mean bigger immediate write-offs on all professional and office equipment. The new schedules, which apply to all of 1962, won't cover buildings.—MEDICAL ECONOMICS, June 18, 1962.

SUICIDE is one of the few crimes for which the law punishes the failure to commit.—YOUR HEALTH, Pennsylvania Medical Society, Oct. 13, 1962.

MOST SUICIDES occur in April and most homicides take place in July.—YOUR HEALTH, Pennsylvania Medical Society, Oct. 4, 1962.

W. B. SAUNDERS COMPANY ANNOUNCES $15,000 WRITING FELLOWSHIP GRANT

To mark its 75th Anniversary in 1963, The W. B. Saunders Company, medical and scientific publishers, are making available $15,000 for an unusual medical writing award. A distinguished committee will select the grantee.

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Some Major Considerations Involved in the Guide to Interpretation of Chapter 484

Laws of Wisconsin, 1959

In November, 1960, the Commission on Hospital Relations and Medical Education, with approval of the Council of the State Medical Society of Wisconsin, distributed to the membership of the Society a "Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959, Relating to Fee Splitting Between Physicians and Others." Copies of this Guide continue to be available on request.

As a further guide to the interpretation of Chapter 484, the Commission on Hospital Relations and Medical Education has prepared the following memorandum as a supplement to the printed Guide.

INTRODUCTION

IN NOVEMBER, 1960, the State Medical Society issued to its membership a GUIDE TO INTERPRETATION OF CHAPTER 484, LAWS OF WISCONSIN, 1959. The GUIDE was concerned primarily with the legal and contract relationships of certain physicians to hospitals under the above chapter. This *memorandum* is concerned with various legal relationships of one physician to another under the same law, which is Section 147.225, Wisconsin Statutes, 1959. Inasmuch as all members have a copy of the GUIDE, and the complete text of the statutes is reproduced twice in it, no point would be served in repeating the wording in this *memorandum*, except as excerpts from it appear in the text itself.

As a matter of easy reference for the reader, the principal types of contractual relationships between physicians will be enumerated and separately discussed.

Before listing any of the principal "categories" of physician contract relationships, it is believed essential to emphasize the purpose of both the old fee splitting statute, and its 1959 revision. The statute was enacted in 1913, amended in 1915, and as amended, remained unchanged until 1959. It has had no interpretation by the state Supreme Court, but has been considered four times in its earlier form in OPINIONS OF THE ATTORNEY GENERAL OF WISCONSIN. The first two subsections of the former statute forbade fee splitting between physicians, by which was meant the sharing of a fee by non-associated physicians, or payment of money by one physician to another as inducement for sending a patient to the first.

Subsection (3) required physicians and certain others to render separate billings in all situations in which a charge was made to the patient. A fair reading of that subsection makes it clear that subsection (3) was meant as an additional method or device by which to avoid the splitting of fees with other physicians, non-physicians, or corporations.

The 1959 revision of the fee splitting statute deleted the first two subsections of the earlier law and substituted as subsection (1) the substance of what had earlier been subsection (3) of the old statute. The principal changes were the elimination of the former requirement that a nurse or anesthetist had to bill separately, since it was believed that the statute was not meant to include non-professional services.

The balance of the 1959 statute contains provisions which are new in part, and in part clarification of the earlier statute. Those which are involved in this *memorandum* will be referred to in subsequent text.

The 1913 statute, as amended in 1915, was so severe and became so antiquated that, as a practical matter, it was unworkable and non-enforceable. In recognition of this fact, efforts were made in the revision of 1959 to provide a more practical statute, with at least some improvement over the earlier drafting. It is not suggested that the statute is an ideal one in its present form, but rather that it represents substantial progress over and, at least a partial modernization, of the earlier one. Further, its underlying purpose has not changed.

The purpose of subsections (1) and (2), enacted in 1913, which is also the purpose of subsection (1)

of the 1959 statute, was very well set out just a year after enactment of the original statute. It is contained in a definitive opinion by the Attorney General of Wisconsin offering the first interpretation by that office as to the purpose and operating effect of the fee splitting statute. It is dated June 15, 1914, and is found in Volume III. OPINIONS OF THE ATTORNEY GENERAL OF WISCONSIN, beginning at page 218. The Opinion states as follows, at page 219:

> "The object of this law, as I understand it, was to prevent the practice, which was alleged to have grown up in this state, of physicians and surgeons in the larger cities, paying fees or commissions to the country physicians and surgeons for inducing or advising patients to submit to operations or treatments by such city physicians and surgeons. Such fees or commissions were not for any services rendered to the patient, but purely a service rendered to the other physicians or surgeons in the way of sending them this business. Generally it was not known to the patient that this fee or commission was being paid. It was felt that this was an abuse, as it made it an inducement for the physician or surgeon first consulted to induce or advise the patient to submit to treatment or operation by the city physician or surgeon offering the largest fee or commission, regardless of his ability or skill."

Subsection (3) enacted in 1915 provided in part that corporations, which would include hospitals, must bill separately from a physician, surgeon or medical assistant where a charge was made to the patient for professional services or advice.

DEFINITIONS

When used in this *memorandum* or the GUIDE, the following words mean:

Employee

A person who agrees, in consideration of direct or indirect gain or profit, to engage in an employment, including the rendering of professional services, under the control or direction of his employer. The employment arrangement may call for part time as well as fulltime services. The fee splitting statute forbids the employment of a physician by a Wisconsin hospital, and general law forbids the practice of medicine by any corporation, unless incidental to teaching or the operation of a public institution.

Employer

A person who engages the services of another, including a physician, and retains control and direction over (1) the rendition of the hired services, (2) the employee himself, and (3) the place of employment. The essence of the relationship is the *right* rather than the *fact* of control over the work or services, the methods used, and the hours, place and conditions of employment. The test is whether the employer *could*, not whether he *did* exercise such control or direction.

Independent Contractor

A person under agreement to perform certain work or services, including professional services, who is held *responsible* for the *result*, and who *retains* the *right* to control the manner of doing his work or performing his services. An independent contract is *not* an employee, and thus is not under the direction or control of the person engaging his services. The word "consultant" as it appears in subsection (3) of the fee splitting statute means an independent contractor who makes the kind of arrangement with a hospital which that subsection authorizes.

Partnership

A partnership is a voluntary and intentional association of two or more persons, who have the capacity to contract, to carry on in common, for profit and as co-owners, a business or profession. The sharing of gross or net receipts does not of itself establish a partnership under Wisconsin law.

All partners are agents of and can legally bind the partnership. The partnership is liable for the negligence or other wrongful act or omission of any partner, acting in the ordinary course of business of the partnership. In any such situation, the partnership is liable for such negligence to the same extent as the partner so acting or omitting to act.

It has been said that a partnership is created when persons join together their money, goods, labor or skill, for the purpose of carrying on a trade, business or profession, and when there is a community of interest in the profits and losses.

Public Policy

Public policy is that principle of law which holds that no person can lawfully do that which has a tendency to be injurious to the public, or against the public good. Where a contract belongs to this class, it will be declared void, although in the particular instance no injury to the public may have resulted and no illegal or immoral purposes were accomplished. In other words, its validity is determined by its general tendency at the time it is made, and if this is opposed to the interests of the public it will be invalid, even though the intent of the parties was good and no injury to the public would result in the particular case. The test to be applied is not what is actually done, but that which may or might be done under the terms of the contract; it is the evil tendency of the contract and not its actual injury to the public in a particular instance.

In general, if an agreement binds the parties or either of them to do, or if the consideration is to do, something opposed to the public policy of the state or nation, it is illegal and absolutely void, however solemnly made.

The law looks to the general tendency of such agreements, and it closes the door to temptation by refusing them recognition in any of its courts. Thus, an agreement for a pecuniary consideration made by a railroad company for the location of a depot is void, although the location in the particular case may be advantageous to the public. Also, an agree-

ment to influence legislation is void, although the legislation sought may be clearly beneficial, and, an agreement to influence an appointment to office is void, although the intent may be to secure the best qualified person. Agreements whose tendency is to suppress competition or raise prices are void, although they may not in the particular case actually destroy competition or enhance prices.

Primarily, it is for the lawmakers to determine the public policy of the state. In arriving at the public policy of a state, legislative enactments must yield to constitutional provisions, and judicial decision must recognize and yield to constitutional provisions and legislative enactments. Where the legislature has enacted a constitutional statute on the subject, public policy is what the statute enacts, regardless of a judge's individual judgment or private notions or convictions. Many agreements, therefore, void because contrary to the statute, are also void as being contrary to the policy of the law as expressed in those statutes.

PHYSICIAN CONTRACT RELATIONSHIPS

1. *Partnership*

This matter was discussed on pages 4–6 of the GUIDE. The statutory exception has reference only to partnerships (see Definitions, pages 5 and 6), between individuals holding an unlimited license to practice medicine and surgery in Wisconsin. Section 147.225 (2), as revised in 1959, provides, in substance, that two or more physicians who have entered into a bona fide partnership for the practice of medicine, may lawfully render a *single* bill for such services in the name of such partnership. For the convenience of the reader, we repeat part of the text contained in the GUIDE on page 6, which stated:

> "This means in substance that there must be a genuine, provable contract between such physicians, and that a 'good faith' partnership does not include one created for some single occasion or circumstance, or a pretended arrangement between two or more physicians set up for the primary purpose of avoiding the statutory requirement of separate billing in subsection (1). The filing of partnership income tax returns would ordinarily indicate the good faith of the organization."

Two questions may be raised with reference to the exemption of medical partnerships from the requirement of multiple billing. The first is whether a partnership must be on a full time basis in order to be "bona fide" as the statute requires. Ordinarily, it is believed that a bona fide partnership for the practice of medicine would mean a full time arrangement between two or more physicians. Undoubtedly, it is possible for physicians to agree in good faith upon a partnership which is not full time, provided (1) it is on a continuing basis, (2) is not designed for avoidance of the statute's requirement of separate billing, and (3) there is some objective evidence of the arrangement between the parties. We cannot over-emphasize the basic importance of first, a written agreement in which, typically, expenses and losses as well as gains, are shared; second, the public announcement of the fact of the partnership; and third, the regular annual filing of partnership income tax returns.

A second question is whether a physician employed by a medical partnership is within the exemption of a single billing in the name of the partnership, as permitted to partners by subsection (2) of revised Section 147.225. We answer this in the affirmative (see Definitions page 4 for meaning of "employee" and "employer").

Inasmuch as the statute does not directly or by implication forbid employment of a physician by a partnership, and inasmuch as the employed physician is actually a professional extension of the partnership, legally answerable to the partnership and subject to its control and direction, the partnership bills for professional services may lawfully include those performed by an employed physician acting within the terms of his employment agreement and the policies of the medical partnership. A partnership which by statute can bill for its partners can bill for its physician employees.

2. *Physician Employee of Individual Physician*

The question has been asked whether the separate billing requirement of subsection (1) of the revised fee splitting statute applies to a physician employee of an individual physician. (For meaning of "employee," see Definitions, p. 4.) It is certainly clear that the fee splitting statute does not, directly, or impliedly, forbid the employment of one physician by another. At most, the statute prescribes the manner of billing under such an arrangement.

It is concluded that so long as the employment relationship is a bona fide one, which means among other things that it was not made for the purpose of avoiding the statute, a single billing for the professional services of the employed physician may be rendered through his physician employer, or even combined with separate professional services rendered by such employer. The reasons for this conclusion are two.

First, the practice of fee splitting, which the old and new statutes were designed to prohibit, did not extend to or include the employment relationship under discussion here. While the question was not directly before him, and the answer was somewhat reserved, the Attorney General stated as follows with reference to the question of an employed physician at page 219 of the 1915 OPINION earlier cited in this *memorandum:*

> "It would seem that it was intended not only to prevent the paying of these fees or commissions, but also to prevent the employment by one physician or surgeon of another, except, possibly, that one physician may employ another upon salary, and not . . . be paid a separate compensation for each case."

Second, as a matter of general law, the employed physician is considered for many purposes the extension and legal responsibility of his employer. (For meaning of "employer" see Definitions, p. 4.) This is true even though the employee may be personally responsible and legally liable for his negligence, and even though the employer may be entitled to recover against a negligent physician employee.

An employed physician is, by definition, under the supervision of his physician employer in the broad sense that the latter may lay down basic policies of treatment, the manner of handling patients and the like. In other words, an employed physician is under the general direction and control of his employers, whether or not such control and direction are exercised. The employer, as the owner of the practice, is the appropriate individual to render the statement for the professional services performed under his general direction, even though not necessarily by him. The medical practice is his, not the employed physician's, and the patient looks to him for counsel and satisfaction.

Where a physician is employed by another, the latter may deduct the compensation of the employed physician as a business expense and must withhold social security and income taxes. If such an employer physician employs enough people, he must also include the employed physician on his workmen's compensation policy and must pay unemployment compensation to the state and federal governments for him. He would do well to report the fact of such employment to his malpractice carrier even though the employed physician should be urged, if not required, to carry his own professional liability policy.

3. *Locum Tenens*

An answer to the question whether a physician may bill for the locum tenens who is conducting his practice depends upon the legal nature of his relationship to such locum tenens. If the locum tenens is an employee of the physician, Section 2 of this memo applies. If the locum tenens is an "independent contractor," (see Definitions, p. 4.) he must then bill in his own name.

4. *Medical or Surgical Assistant*

A physician who assists another, and who is (1) a bona fide partner or (2) an employee of the physician he assists, need *not* bill separately for his professional services for reasons indicated in Sections 1 and 2 of this *memorandum. Unless* the assisting physician is a partner or employee, however, he must bill *separately* under the mandatory provisions of subsection (1) of Section 147.225, as revised in 1959.

5. *Circuit Rider*

Physician specialists, who serve more than one hospital, may, beginning in 1961, have the type of contract arrangement contained in the 1959 law, subsection (3), discussed on pages 6 to 14 of the GUIDE. The fact that they serve on a part, rather than a full time basis for a given institution, does not disqualify them under the statute, but neither does it exempt them from its terms.

If a particular "circuit rider" specialist renders consultation to the staff only and does not use the facilities of the hospital, he need not have a contract with the hospital beyond staff privileges. In such event, such specialist must render his own billing for professional services unless he is an employee or partner of the physician or physicians to whom he renders such services.

6. *Consultant to Partnerships or Clinics*

Arrangements exist in this state under which a specialist (or more than one specialist) acts as the regular "consultant" to a partnership of physicians, including a group designated as a clinic. Such consultants might be available one day a week at the offices of the group for consultation and to examine and treat such patients as were scheduled for that occasion. In other situations, they might be available on call, as needed. While several types of financial arrangements are possible, it is assumed here that typically such consultants would be paid on a fee for service basis.

The question has been raised whether under such a professional arrangement, the specialist must bill the patient separately and directly, or whether his charge may be included in the total charge for professional services rendered by or through the medical group for which the specialist is a consultant.

The answer to this depends upon the legal relationship between the medical group and the consultant. If his status is that of an independent contractor, the consultant must bill separately. If the consultant is, in fact, either the bona fide partner or employee of the medical group, even on a part time basis, and this can be satisfactorily established, the medical group could then properly bill for reasons set out in Sections 1 and 2 of this *memorandum.* The word "consultant" here does *not* have the same meaning as it does when used in subsection (3) of the revised statute.

7. *Fee Arrangements*

Whether a particular physician is paid on a fee for service basis, a percentage of total professional charges rendered by the physician or group which bills, or a salary, does not of itself determine the legal validity of the billing under the revised fee splitting law. What is of underlying importance is the legal relationship between the physician who performs the services and the physician or group which has arranged that he do so. The method or device for billing becomes important as evidence of an alleged or asserted legal relationship, rather than the converse.

SUMMARY

It is important to take a common sense view of the fee splitting statute, especially in the absence of any court decisions interpreting it. The revised statute of 1959 is designed to cure two and only two

practices on the part of some physicians, namely, (1) the undisclosed splitting or sharing of professional fees by non-associated physicians, and (2) the employment of physicians by hospitals.

Because of the criminal penalties attached to its violation, the fee splitting law is known as a penal statute. Such a statute is subject to strict or narrow construction by courts and enforcement officers. There is no need for anyone to interpret this statute more broadly than the courts and public officials are permitted to do.

This statute does *not* set aside the general law of partnerships, of employment, or of other long established legal and economic relationships by associated physicians. It is significant that in nearly fifty years no such questions have reached the courts and that the Opinions of the Attorney General are concerned with non-associated physicians. Such relationships stand unchanged unless the statute clearly and expressly makes such changes. The statute as revised is concerned basically with the requirement of the rendition of separate bills for the professional services of non-associated physicians, and with the outlawing of the employment of physicians by hospitals, other than governmental institutions, and certain teaching hospitals.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (2), Wisconsin Statutes, 1959.

STERILIZATION

The sterilization of individuals, for other than therapeutic reasons, is undoubtedly limited in Wisconsin to those cases specifically authorized by statute. An institutionalized criminal or mentally diseased person, under Sec. 46.12 Stats., may be sterilized provided that the elaborate precautions set forth in that statute are followed.

A physician who sterilizes a person for any but clearly therapeutic reasons may be guilty of performing an illegal operation. For that reason it is recommended that additional physicians be called in consultation to determine the therapeutic advisability of the procedure.

The illegal character of any but a therapeutic sterilization would not be altered because the patient or his representative consented in writing to the operation.

Reference: Section 46.12, Wisconsin Statutes, 1959.

CAN YOU PRACTICE WITHOUT A LICENSE?

Suppose you are just out of military service. Or you have just arrived in Wisconsin from another state. Dare you practice, either on a temporary or permanent basis, before you get your license?

Suppose you enter practice in association with one or more other physicians. May you practice before your licensing is complete?

Be careful! Your good intentions may be illegal practice. You may be subject to sharp criticism, or worse.

The best advice: Postpone any contact with patients until your Wisconsin licensure is complete.

The next best advice: Be circumspect. Issue no prescriptions over your own signature. See patients only in consultation with your associates who are already licensed. Act only as an apprentice or as a physician's deputy, never as a privately practicing physician.

Reference: Section 147.15 (2), Wisconsin Statutes, 1959.

Responsibility of the Physician Conducting Pre-Employment Examinations

THE following question is frequently raised by physicians and those interested in pre-employment physical examinations. The answer is provided by legal counsel for the State Medical Society of Wisconsin.

Question. What are the responsibilities of a physician to an employer for whom the physician is doing pre-employment physical examinations, to reveal to the employer conditions known to the physician to exist (such as epilepsy) but of which the physician would have no knowledge in the course of the examination except by previously acquired information in his capacity as the examinee's personal physician?

Answer. Unless the examinee authorizes the physician to disclose to the employer information acquired by the physician in his professional capacity as the examinee's personal physician, the physician should make no such disclosures to the employer.

Opinion. At first sight this question may appear to present a dilemma, but it does so only if the physician and employer have failed to define the physician's responsibilities with sufficient clarity. It should be made clear to the employer at the outset that the physician will limit his reports to such facts as are revealed to him during the examination itself, and will not include information acquired by the physician while treating the examinee as a patient.

The physician to whom this situation is presented is quite likely to feel disturbed by two apparently conflicting legal obligations:

(1) His statutory and ethical obligation to his patient to refrain from "willfully betraying a professional secret;"
(2) His contractual obligation to the employer to disclose all he might know that bears on the prospective employee's fitness for a particular job.

Actually, the physician has only the first of the above mentioned legal obligations. Even if his contract with the employer contained a specific provision requiring the disclosure without the patient's consent of information acquired in the course of professional treatment, that provision would undoubtedly be held void by any court passing upon it, as being contrary to the public policy implied in the protection of secrecy afforded by Section 147.20 (1) (b) of the Wisconsin Statutes.

The real problem, therefore, is not a legal one. Rather, it is a problem in communications. The employer, quite possibly unfamiliar with the physician's legal and ethical obligations to his patients, might find it difficult to understand how the physician could be so lacking in candor as to fail to disclose all information for which the employer may feel he has contracted. The obvious solution to this problem of communication is to inform the employer, preferably at the time of contracting, that the physician's reports will cover only the information obtained at the time of the physical examination made at the employer's request. If this was not made clear to the employer at the time the physician and employer originally contracted for the pre-employment examinations, the physician would do well to clarify the arrangement at a later date, being careful, of course, to refrain from doing so in such a manner or at such a time that the employer would be likely to suspect that one particular employee had a serious health problem.

Another solution, more drastic than is really necessary, would be for the physician to exclude from the list of those on whom he would make pre-employment physical examinations, all persons who had previously consulted him as patients. Such a solution is recommended only if the physician, in making such examinations, finds it difficult to conduct the examination as if he did not know what actually he does know from prior diagnosis or treatment.

GUIDE TO THE SERVICE CORPORATION LAW

Extra copies of the "Guide to The Service Corporation Law" are available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

This Guide is a series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

Every member physician of SMS was sent a copy some time ago, but extra copies are available if needed.

Legal Limitations on Treating the Sick in Wisconsin

An Interpretation of The Medical Practice Act

HISTORICAL DEVELOPMENT

OVER ONE HUNDRED years ago the medical profession organized nationally for the principal purpose of elevating the standards of medical education and encouraging adequate licensing laws throughout the states.

In a period of less than 20 years before the organizational meeting of the American Medical Association in 1847 at Philadelphia, the number of medical schools in the United States had doubled. Most of these schools were commercial in nature, and their promoters sought to increase enrollment by reducing curriculum requirements and easing graduation and licensing requirements. Sixteen weeks was the accepted length of the college term. Some schools reduced this to thirteen weeks.[1]

The ratio of physicians to population was five times as great as in France, and it was felt that the over supply of doctors and inadequate medical education were "largely responsible for the rise of quackery and charlatanism." [2]

At least as early as 1835 efforts were made by responsible medical colleges and individual eastern state medical societies to upgrade medical education and—of equal importance—to divorce teaching from licensing.

It was soon recognized that these efforts, if they were to be effective, must be made through a concerted, organized national movement.

In 1845 the New York Medical Society adopted the following resolution:

> "WHEREAS, It is believed that a national convention would be conducive to the elevation of the standard of medical education in the United States; and
> "WHEREAS, There is no mode of accomplishing so desirable an object without concert of action on the part of the medical colleges, societies and institutions of all the states; therefore be it
> "*Resolved*, That the New York State Medical Society earnestly recommends a national convention of delegates from medical societies and colleges in the whole Union to convene in the city of New York on the first Tuesday in May in the year 1846 for the purpose of adopting some concerted action on the subject set forth in the foregoing preamble.
> "*Resolved*, That a committee of three be appointed to carry the foregoing resolution into effect." [3]

Morris Fishbein, M.D., states in his book, *A History of the American Medical Association*, p. 22, that this resolution "may be considered the first step toward the formation of the American Medical Association as we know it now."

Organizational problems, lack of cooperation by many medical colleges and public apathy impeded progress.

By 1893, however, fifteen states had enacted medical practice acts which required state examinations of all those who desired to practice medicine.[4] This was the breakthrough, and in a few years most states had adopted similar requirements.

The substantial improvement in the standards of medical education developed at a somewhat slower pace. It was not until 1907 that medical school inspection and rating by the Council on Medical Education gained public recognition and became truly effective. At that time there were 160 medical schools; 82 had been rated above 70, 46 between 50 and 70, and 32 below 50. Medical schools conducted solely for profit and night schools were condemned.[5]

It has, thus, been only during the past 50 years that the states have adopted effective Medical Practice Acts which restrict the unqualified and impose minimal requirements upon those seeking medical licensure. The same may be said of the voluntary efforts to elevate medical school requirements and standards.

Wisconsin presents a typical picture of Medical Practice Act development through the years. It is a story of legislative response to public demand for protection against the incompetent, the quack, the cultist and the charlatan.

The first halting legislative step seeking qualified practitioners appeared in Chapter 27, Revised Statutes of Wisconsin, 1849. It imposed the duty of examining medical students upon the censors of the county and state medical societies.

Successfully completing his examination, the student paid the president of the society $10 for a diploma and membership in the society. This dip-

loma and membership was little more than a badge of honor.

This regrettable state of statutory laxity continued until 1897 when the Wisconsin Legislature enacted our first real Medical Practice Act.[6] This act established the first state board of medical examiners of seven members appointed by the Governor. Three of the appointees were "regular physicians," two were "homeopathic physicians," and two were "eclectic physicians."

The homeopaths and eclectics in Wisconsin each had their own state societies which reflected a national pattern of developing cult practices. Dr. N. S. Davis, the first editor of the *Journal of The American Medical Society*, in a speech before medical editors in Cleveland on June 5, 1883, said:

> "It has appeared from the review of the past that, during the first twenty-five years of our national existence, laws were enacted in nearly all the then existing states designed to protect the people from the impositions of ignorant and designing men claiming power to heal the sick, by prohibiting unlicensed practice, etc.; but which were nearly all repealed or so amended as to render them inoperative during the next thirty years by means of popular prejudices and false representations attendant upon the rise and spread of Thompsonianism and homoeopathy; the one playing upon the mind of the masses with all the power of bold and ignorant empiricism, and the other captivating the credulous tendencies of the more fashionable circles by a mystic transcendentalism inclosed in sugar pellets. The first has died a natural death, leaving a sickly offspring bearing the name of eclectics, while the second, like some medicines, retains its name as a 'trade mark,' and its organization for political influence, while its once transcendental vagaries have long since practically ceased to exert an influence over the treatment of disease."

The homeopaths and eclectics, as standards of medical education improved, gradually abandoned their exclusive theories of treatment and were assimilated into medical practice.

It was not until the 1953 session of the Wisconsin Legislature, however, that the last vestiges of homeopathy and eclecticism were removed from the statutes. In that year the legislature altered the make-up of the board to eliminate the homeopathic representative.

As noted, Wisconsin first enacted the beginnings of an effective Medical Practice Act in 1897 with the establishment of a state examining board. Anyone entering medical practice following its enactment was required to be licensed by the board.

It is interesting to compare the license application requirements, then and now. An applicant had the alternative of submitting to an examination "in the various branches of medicine and surgery" or presenting to the board a diploma from a medical college which required "at least three courses, of no less than six months each, before graduation."[6] Thus practical training with a "respectable" physician remained an avenue to licensed medical practice, but the pattern of effective control of medical qualification was established.

The 1897 Act made no provision for the licensing of those already in medical practice or the date it became effective. The very next legislature required "every reputable physician of good moral character" who wished to continue in practice to register with the board and to present a diploma or other credentials. A registration certificate was then issued which was required to be filed with the county in which the physician practiced. Criminal penalties were provided for noncompliance.[8]

It was only 60 years ago, then, that the unlicensed or uncertified practice of medicine could be prohibited by criminal prosecution.

This requirement of medical license or certificate was a blow to osteopathy whose practitioners had, by this time, established themselves in Wisconsin. The legislature, in its 1901 session, added an osteopath to the board of medical examiners, provided for an examination and licensure in osteopathy, but permitted all those already in practice to continue under a typical "grandfathers" clause.[9]

This same legislature increased the requirements for medical education to four courses of not less than seven months with at least an equivalent of two years of high school and, more significantly, required both an examination and a diploma as a condition to medical license. Those presenting a diploma from a medical school in Wisconsin, however, were exempt from the examination requirement.[9] These amendments marked an end to practical experience with a preceptor as an alternative to medical school education for licensure.

As with eclecticism and homeopathy, the osteopaths gradually began to abandon their cult theory and practice. There was evidence that some of their schools were interested in and were improving their standards and facilities.

In 1949 the Medical Practice Act was amended to eliminate separate licensing of osteopaths. Thereafter licenses to practice medicine and surgery were issued, under the usual conditions, to applicants presenting diplomas from a "medical or osteopathic college with standards of education and training substantially equivalent to the University of Wisconsin Medical School, approved and reorganized by the board."[10]

Osteopaths then in licensed practice were permitted to enroll in a prescribed course in materia medica and pharmacology and, upon successfully completing an examination by the board in those subjects, received an unlimited license to practice medicine and surgery upon surrender of their old license.[10]

As has been seen, effective criminal machinery was available by 1899 to restrain and eliminate unqualified and unlicensed practice in Wisconsin. Apparently, a lack of early and forceful enforcement permitted chiropractic to gain a foothold in Wisconsin by 1915. Clearly they were engaged in medical practice for which, as today, they were incompetent

and unqualified. They were neither licensed nor certified by any state agency.

The 1915 Wisconsin Legislature passed a statute authorizing chiropractors to practice so long as they did not hold themselves out as licensed or registered —and, for good measure, gave special licensure recognition to the itinerant practitioner of medicine or osteopathy.[11]

Then, in a sharp reversal of form, the same legislature substantially increased the educational requirements upon those who applied for a license to practice medicine and surgery.[11]

This important chiropractic breakthrough seriously threatened the entire structure of those laws designed to assure that those who treated the sick in Wisconsin were qualified to do so. In effect the legislature was imposing increasingly more rigorous requirements upon those who were qualified and none whatsoever upon those who were not.

Lurking in the background at this time were the naturopaths, the naprapaths, the faith healers, quacks, charlatans and other cultists ready and eager to follow the lead of the chiropractors to unqualified legislative recognition—or exemption from educational and training requirements.

Thus, one of the significant legislative actions in the development of our Medical Practice Act was the enactment of the Basic Science Law by the 1925 Legislature. It will be considered in some detail later. Generally, however, and with some limited exemptions, it imposed minimal qualifications upon all who would treat the sick in Wisconsin. It is so inclusive in its scope that it is the law most frequently used in prosecutions against the unlicensed.[12] It has effectively subdued the quacks and all cult groups other than the chiropractors who received license recognition in the same session of the legislature.

In summary, Wisconsin joined with other states a hundred years ago in appreciating the absolute need for the imposition of adequate standards to assure qualified health care to its people. These legislative standards and the mechanisms through which they could be enforced developed and improved through the years.

Wisconsin, as did the other states, experienced the growth of cultism and potent efforts to undermine qualifying legislation which had been so painstakingly achieved. The development of these cults and the legislative treatment of them has been briefly traced. The present state of the law will now be examined in some detail.

THE BASIC SCIENCE LAW

General Provisions

In 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin Legislature enacted the Basic Science Law, being the first state to do so. The majority of the states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does not authorize one who has successfully passed the examination to engage in any form or manner in caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and physical diagnosis,[13] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless be has a certificate of registration in the basic sciences.[14] But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.[15] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.[16]

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the Army, Navy, and Federal health service,[17] registered nurses,[18] dental hygienists,[19] optometrists,[20] and persons practicing Christian Science.[21] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[22] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[23]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin were granted the opportunity of being registered upon application to the board.[24] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

Definition of "Treating the Sick" All Inclusive

Section 147.01 (1), Wisconsin Statutes, 1959, defines what constitutes treating the sick in Wisconsin:

> "(a) 'To treat the sick' is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof."
>
> "(b) 'Disease' includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

Even such minor departures from complete health, as astigmatism, headaches and partial paralysis,

constitute "disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[25] The use of roentgenography for diagnosis and treatment is treatment of the sick.[26] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[27] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[28]

Board of Examiners in the Basic Sciences

The State Board of Examiners in the Basic Sciences consists of three lay educators appointed by the Governor to serve for a term of six years each.[29] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[30]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, and all other disbursements by the board, may not exceed in amount the fees received.[31]

Application for Certificate

Application for a certificate of registration must be made to the Board of Examiners in the Basic Sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[32] The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.[33]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[34]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[35] The applicant is examined in anatomy, physiology, pathology and physical diagnosis,[36] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be re-examined in that subject at any examination within one year without further fees, but if he fails in two or more, he must re-apply and be re-examined in all subjects.[37]

If the state boards of medical or dental examiners accept in whole or in part certifications from their national boards of examiners, the basic science board may accept such national certificates in lieu of their own examinations.[38]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[39]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[40]

Court Review

The action of the board in granting or denying a certificate is subject to review by appeal in the manner provided in Chapter 227, Wisconsin Statutes. The applicant affected, or any state examining board for any branch of treating the sick, may take such appeal.[41]

The court may then affirm, reverse, or modify the decision of the board.[42]

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in Section 147.20, Wisconsin Statutes.[43] For discussion of that section and procedure under it see "Revocation or Suspension of License," page 11, of this article.

Enforcement of the Basic Science Law

The definitions of "treat the sick" and of "disease" are sufficiently broad to encompass even the "hair restorer" and the "headache reliever" as has been seen. All who "treat the sick" are required to have a certificate in the basic sciences with the noted exceptions.

Of equal importance is the fact that the law is readily enforceable. In addition to a criminal penalty of a fine or imprisonment,[44] the board of medical examiners or the district attorney of the proper county may bring action in the name and on behalf of the state to enjoin a violation.[45] It has been the latter procedure which has proved most effective.

LICENSING REQUIREMENTS AND PROCEDURES

As has been noted, a basic science certificate does not entitle its holder to treat the sick. This is further clarified in Section 147.14 (1), Wisconsin Statutes, 1959:

"147.14. Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating the sick as the term 'treat the sick' is defined in s. 147.01 (1) (a), without license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute."

Several exceptions to this provision are created by virtue of a statutory provision that exempts those engaged in healing the sick through Christian Science,[47] while still another provision exempts from licensure requirements those engaged as commissioned officers of the Army, Navy, or Federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[48]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin may not be pursued as a vocation. This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[49]

Each specific licensed field in Wisconsin is under the jurisdiction of one of the several licensing boards. The State Board of Medical Examiners licenses applicants for the practice of medicine and surgery, physical therapy, and podiatry.

Other than medicine and surgery, each licensed field of practice is limited by law either in the scope of its practice or in the modalities or treatment methods it may apply. It is not the purpose of this article to set forth those limitations. Licensure requirements, application procedures, powers and organizations of the respective licensing boards, license revocation and disciplinary procedures will be treated, however, as will statutory provisions of particular interest and importance to the particular field of practice involved.

MEDICINE AND SURGERY

Examining Board

The examining body for applicants for license to practice medicine and surgery is the state board of medical examiners, which is composed of eight licentiates, one of whom must be an osteopath, appointed by the governor for four-year terms.[50] No instructor, stockholder, member of, or persons financially interested in any school having a medical or osteopathic department, is eligible.[51]

The board has its permanent office in Madison and is required to meet at least four times a year, one meeting of which must be on the second Tuesday of January at Madison for the purpose of electing its officers.[52]

It keeps a register of the applications it receives and the licenses and certificates of registration issued.[53]

All persons licensed or registered by the board are required to register with it annually and pay the required fee. These include those licensed to practice medicine and surgery;[54] osteopaths,[55] podiatrists,[56] and physical therapists.[57]

This annual re-registration requirement must be complied with in January of each year and the board is required to publish a printed list of all registrants before March 11 and mail a copy to each registrant and to designate law enforcement officials including the sheriff and district attorney of each county.[58]

All applications for licensure from the board must be presented at the time and place designated by it.[59] In this connection, the board in the exercise of its inherent rule-making authority, has adopted a wide range of regulations detailing its specific requirements as to the procedure in making application for licensure.[60] These are subject to frequent change; therefore, it is suggested that specific inquiry be directed to the offices of the State Board of Medical Examiners, State Capitol Building, Madison, Wisconsin.

Educational Requirements

The minimal educational requirements of an applicant for license to practice medicine and surgery are summarized in Table 1, Column 1, page 8.

The medical or osteopathic college from which the applicant has graduated must be "substantially equivalent" in its standards of education and training to the University of Wisconsin Medical School and approved and recognized by the board on this basis.[61]

Inquiry as to whether a particular college has been approved should be directed to the office of the board. As to colleges not already approved and recognized, the board or a designated agent is required to conduct an investigation and a public hearing with notice to all interested parties.[62]

Examination and Licensure

The State Board of Medical Examiners examines all applicants in subjects usually taught in a reputable medical school.[63] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[64]

TABLE 1—*Requirements of an Applicant for a License in Medicine and Surgery, Podiatry, Chiropractic, Optometry, Dentistry and Nursing*

Applicant for License in	Preliminary	Undergraduate	Professional and Personal	Additional Requirements	Application Fee
Medicine and Surgery (Secs. 147.15; 147.17(1))	Equivalent to graduation from an accredited high school of this state.	Equivalent to the premedical course at the University of Wisconsin, including physics, chemistry and biology.	Good moral and professional character; diploma from reputable professional college with standards of education and training substantially equivalent to the University of Wisconsin Medical School.	If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital; a verified statement of familiarity with health requirements on communicable diseases.	$45, with an additional $5 if license issued.
Podiatry (Sec. 154.02)	Equivalent to graduation from an accredited high school.	One year in an accredited college of liberal arts or science.	Completion in an accredited school of podiatry, a course in anatomy and physiology of the feet, and diagnosis of foot ailments and deformities, materiamedica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, and minor surgery and bandaging pertaining to ailments of the feet, and the mechanical treatment of congenital or acquired deformities of the feet. Applicant must be of good moral and professional character and more than 21 years of age. No degree which entitles one to practice chiropody shall be accepted from any recognized university or college of podiatry except that of "Doctor of Podiatry" or its equivalent. Any school conferring the "DSC" or its equivalent degree must have a professional curriculum of 4 years, with at least 32 weeks and at least 30 class hours each week, with adequate clinical or hospital facilities.	None.	$25
Chiropractic (Sec. 147.23(3))	None	2 years of study for a Bachelor of Arts or Science degree in a college accredited by the North Central Association of Colleges and Secondary Schools.	Graduation from a reputable school of Chiropractic, approved and recognized by the Board of Examiners in Chiropractic, having a residence course of not less than 36 months, consisting of not less than 3,600 60-minute class periods. Satisfactory evidence of good moral character.	Certificate of Registration in basic sciences.	$25
Optometry (Secs. 153.04 and 153.05)	None	None	Good moral character, 21 years old. Graduation from an accredited college of optometry approved and recognized by Optometry Board, and 5 years approved training in optometry, of which 3 years must have been in an accredited school or college of optometry.		$35 for resident $50 for non-resident. $10 for subsequent examination in event of failure.
Dentistry (Sec. 152.03)	Equivalent to graduation from a high school or academy in Wisconsin offering a four-year curriculum beyond the 8th grade.	2 years college preparation leading to a baccalaureate degree including English and the sciences, physics, biology and chemistry.	Satisfactory completion of dental school and college recognized by the Wisconsin State Board or Dental Examiners with a curriculum of at least four years of 32 weeks each.		$25
Nursing (a) Registered Nurse Sec. 149.04	Equivalent to high school education.		Good moral character, citizen, or intends to be citizen. Diploma of graduation from an accredited school of nursing.		$25
(b) Practical Nurse Sec. 149.09(2)	2 years of high school or equivalent.		Good moral character, citizen, or intends to be citizen, 18 years of age. Completed work prescribed by an accredited school for trained practical nurses approved by the board.		$15

Licensure without Examination

The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the Army or Navy, or of the Federal public health service, upon filing of a sworn and authenticated copy of his discharge.[65]

Applicants from Unapproved Foreign Medical Schools

As has been noted, an applicant for a license to practice medicine and surgery must present to the board of medical examiners a diploma from a medical or osteopathic college *approved and recognized by the board*. A number of foreign medical schools are not. Some which are, have that approval only during specified graduating years.

A carefully restricted opportunity for applicants who cannot present a diploma from such an approved school was provided by the 1957 session of the Wisconsin Legislature.[66]

If the board is persuaded that a graduate of an unapproved and unrecognized foreign medical school has preprofessional and professional training substantially equivalent to that offered by the University of Wisconsin premedical and medical schools, it may admit the applicant to examination and issue a license to practice medicine and surgery.

The board may ask the dean of a medical school, which has been approved by the board, to examine or have examined the applicant to determine whether the pre medical and medical training is substantially equivalent to that offered in the dean's school. In lieu of the inquiry of a dean, the board may accept, either in whole or in part, the marks received by the applicant in examinations conducted by the educational council for foreign medical graduates.

Only 25 licenses a year may be issued to applicants. The fee is based upon the time of the examiner and board but is not less than $100 or more than $300.

Temporary Licenses to Practice Medicine and Surgery

Several months may elapse between the time an obviously qualified physician applies for a Wisconsin license and the board conducts its next examination.

Provision has been made by statute under which any two officers of the board of medical examiners may cause to be issued a temporary license to practice medicine and surgery to such an applicant.[68]

Two such officers must first find, however, that an emergency need for medical personnel in a particular area exists and the temporary license must limit its holder to practice in that area.

This statute contemplates that the temporary licensee will submit to the next board examination for permanent license. To that end a temporary license expires within 30 days after the next examination for permanent license is conducted by the board or on the date the board grants or denies the applicant a license—whichever date first occurs. If the temporary licensee does not take the examination, the license expires on the day the board begins its examination of applicants.[69]

A temporary license may be issued only once to the same person; and, during the period it is in force, the basic science law certificate requirement is suspended, assuming the temporary licensee has applied for a basic science certificate and the application has been accepted by the basic science board.

The fee for a temporary license is $25.

Temporary Educational Certificates in Medicine and Surgery

For the stated single purpose of providing opportunities in Wisconsin for the postgraduate education of certain persons in medicine and surgery who do not possess a license and, presumably, are not eligible for one, the board of medical examiners may issue educational certificates under prescribed conditions.[70]

An applicant for such a certificate must have training in medicine and surgery satisfactory to the board. It may be issued for a period not to exceed one year. It may be renewed annually, at the discretion of the board, for not more than four additional years. No more than 50 temporary educational certificates can be issued annually and no more than 150 may be outstanding at any one time.[71]

Limitations on Practice

The certificate permits its holders to take postgraduate educational training only in a teaching hospital which maintains standards prescribed by the board and are commensurate with those of nationally recognized accrediting organizations. He may render services to patients only under the direction of a person licensed to practice medicine and surgery in Wisconsin.

Under such medical direction, the educational certificate holder may prescribe drugs other than narcotics and sign certificates, reports and other papers required, or for the use of public authorities which are required of or permitted to one licensed to practice medicine and surgery.

Additional restrictions are these: The certificate holder must confine his training and practice within the hospital in which he is taking his postgraduate education, and neither he nor the hospital may receive fees or other income for his services from any patients treated by him.[72]

The Status of Externs, Interns and Residents

Externs

The term "extern" or "preceptee" refers to advanced medical students in their clinical years, who have not as yet completed their college course in medicine. A preceptee performs certain assisting and observing functions, either during a vacation period, or during his fourth year of medical study, under the supervision of a licensed physician. Preceptees participate in this portion of their training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

A preceptee is generally an assistant to a physician. The duties delegated to a preceptee by a physician are usually very much limited and relate only to observation. Thus, a situation would seldom arise in which an act of a preceptee might cause injury. A physician presumably has the duty to see to it that the preceptee is delegated no duty which would call for discretion or judgment on his part. However, a negligent act on the part of a preceptee in the treatment of a patient is a responsibility of the physician under whom he is working.

Interns

An "intern" is generally understood to mean one who is engaged in a twelve months' period of advanced study immediately subsequent to the completion of his college course and prior to the granting of his medical license. Internship is a prerequisite for the granting of a license to practice medicine and surgery in Wisconsin. After one year of internship, unless his medical school requires a longer period of internship as a condition of graduation, the intern must be licensed and have the legal status of a practicing physician.

An intern does not have the full legal status of a licensed practitioner. He does have certain functions of a medical nature which he is permitted to perform. The Wisconsin Supreme Court has admitted that interns are not subject to the Medical Practice Act because the Wisconsin Statutes require an internship as a part of one's medical education prior to licensure. The court summarized the legal status of an intern in Wisconsin as follows:

> "This is a legal sanction of the performance of such duties on the part of interns as are usually and ordinarily performed by them. The performance of such duties does not constitute the practice of medicine, or a representation

that the intern is authorized to practice medicine."[73]

Interns are not within the provisions of the so-called "medical privilege statute."

When it comes to responsibility for negligence of interns while performing their customary duties, it is clear that they have a personal responsibility. The responsibility for their acts, however, may extend to the physicians under whom they are working, or to the hospital employing them. The law generally holds the intern to be an employee or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents, within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the Workmen's Compensation Act, which extends employee protection to interns injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of interns in the performance of duties which are customarily performed by them. However, where the intern is acting under the direct supervision of a physician during the course of an operation, the hospital is absolved from responsibility and his acts become those of the physician who has charge of the work.

Residents

A "resident" is usually understood to mean a physician engaged in postgraduate medical education beyond the period of internship, and under the supervision of a hospital medical staff or a medical faculty. A resident is required by Wisconsin law to hold a regular, permanent license to practice medicine. He is as fully responsible for his acts or omissions as any other licensed practitioner.

Itinerants

The following statute specifically governs licensure of the itinerant practitioner to practice any form or system of treating the afflicted:

> "147.18 Itinerants. Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners."

Revocation or Suspension of License

Four procedures have been established by statute for the revocation or suspension of a license or certificate issued by the Wisconsin State Board of Medical Examiners:

By Civil Action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke or suspend his license upon a verified complaint received by him charging the holder of the license with having been guilty of immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[74] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

> "(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of 'lost manhood,' the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses reestablished, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee, or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude; (g) engaging in conduct unbecoming a person licensed to practice or detrimental to the best interests of the public."

The license of a physician who attempts to perform an abortion may be revoked or suspended, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[75] Nor is the time within which to bring such action, after the offense has been committed, important.[76] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty as an accessory before the fact, and his license is subject to revocation or suspension under this section.[77]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under section 147.20.[78]

By Action of the Board

The statute also provides that when any person licensed by the State Board of Medical Examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke or suspend

the license or certificate. The board is likewise under a duty to revoke or suspend any such license or certificate upon proof of a Federal conviction of a crime committed in the course of the holder's professional conduct.[79]

The license of a physician who has been convicted of a crime cannot be revoked or suspended by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked or suspended by a circuit court action described in part (a) of this section.[80]

Revocation or suspension of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[81] There is no time limitation within which the board must act. In the event, however, that the board suspends rather than revokes the license or certificate, the suspension must be for a definite period not exceeding two years, and the board has the power, upon a proper showing, to restore it at any time within the period.[82]

The board has no authority to restore a revoked license.[83] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the State Board of Medical Examiners with a finding by the court that the applicant is of good moral and professional character and that justice demands the restoration.[84]

The 1961 Legislature enacted a new subsection allowing the board, without formal proceedings, to place a license holder or certificate of registration holder on probation and temporarily suspend such license or certificate of registration for two three-month periods. However, the board must know or have good cause to believe that the person has been guilty of immoral or unprofessional conduct. The board may also warn and reprimand the holder of the license or certificate and may request the State Medical Grievance Committee to act. All of the actions of the board under this section are subject to review as provided by law.[84a]

State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[85] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health.

The statute follows:

> **"147.195. State medical grievance committee.** The state health officer, the secretary of the state board of medical examiners, and the attorney general or deputy attorney general or their representatives, are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon. All divisions, officials and employees of state and local government are authorized to cooperate with the committee in conducting investigations and by making available to it pertinent data in their possession."

MASSAGE AND HYDROTHERAPY

The 1953 session of the Wisconsin Legislature repealed that section of the statutes which authorized the registration of masseurs by the state board of medical examiners.[86] It permitted those previously registered to continue in practice under the same conditions and limitations as were imposed by law prior to the repealer.[87] Because there are a number of these "grandfathers" still in practice in Wisconsin, the nature and scope of their authorized practice are set forth.

Limitations on Practice

Masseurs are not permitted to treat a specific disease except upon the advice of a licensed medical physician.[88] Assuming such advice, the masseur is limited to the practice of massage, hydrotherapy and educational gymnastics in his treatment.[89] He may use a galvanic generator, diathermy, infra-red ray, and ultra-violet light for massage purposes.[90]

An opinion of the attorney general defines "massage and hydrotherapy" as: "A method of rubbing, kneading, or stroking of the superficial parts of the body by the hand or an instrument, for the purpose of modifying nutrition, restoring power of movement, breaking up adhesions, etc., and hydrotherapy is the treatment of disease by means of water."[91]

PHYSICAL THERAPY

With the elimination of further registrations in massage and hydrotherapy, the 1953 session of the Wisconsin Legislature, which enacted the masseur repealer, recognized the growth, acceptance, training and education of the qualified physical therapist. It provided authority in the state board of medical examiners to accept applications from physical therapists meeting stated qualifications; to conduct examinations through a committee of physical therapists appointed by it; and to issue certificates of registration to successful applicants.[92]

Physical therapy is defined, by statute, as treatment utilizing "physical, chemical and other proper-

ties of heat or cold, light, water, electricity, massage and therapeutic exercises, including posture and rehabilitation procedures.[93]

Limitations on Practice

Physical therapy, as above defined, is a part of the practice of medicine and some other licensed or registered practices in Wisconsin. Persons licensed or registered in this state, under another law, to engage in a practice which includes physical therapy are not affected by the legal limitations imposed upon it.[94]

All other persons practicing physical therapy or adopting titles, such as "physical therapy technician," must be registered by the state board of medical examiners.[95]

There are further restrictions on the practice. The registered physical therapist may not use Roentgen rays or radium for any purposes nor may he use electricity for surgical purposes, including cauterization.[96] And, most significantly, he may not undertake treatment unless it be under a prescription and the direct supervision of a person licensed to practice medicine and surgery.[97]

OSTEOPATHY

Osteopaths are no longer licensed as such in Wisconsin. In recent years the Wisconsin Legislature became convinced that osteopathy, as with homeopathy, had abandoned its cult background and therapy. It enacted legislation providing that if an applicant presented to the state board of medical examiners a diploma from an osteopathic college *with standards of education and training substantially equivalent to the University of Wisconsin Medical School* and which school was approved by the board, a license to practice medicine and surgery would be issued. This is conditioned, of course, upon the applicant meeting all other prequalification requirements for medical licensure including examination.[98] These are set forth in the table appearing at page 8.

Provision was made in the same legislative enactment through which those osteopaths, previously licensed by the board to practice osteopathy and surgery, could qualify for the unlimited license to practice medicine and surgery. Seeking the unlimited license, the osteopath is required to take a prescribed course, approved by the board of medical examiners, in materia medica and pharmacology and to pass the same examination in the subjects as given to a medical school graduate at any regular meeting of the board.[99]

Limitations on Practice

The graduate of an osteopathic school who holds a license to practice medicine and surgery is prohibited from using the title "doctor of medicine" or the letters "M.D."[100] Other than that his license to practice medicine and surgery is identical in its unlimited privileges as that of the doctor of medicine.

There are a sufficient number of osteopaths, licensed as such, and still in practice, who did not seek or gain the unlimited license to warrant a brief statement of the limitations imposed upon their practice.

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[101]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[102] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[103]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so. . ."[104]

PODIATRY

The practice of podiatry, previously called chiropody, has been legislatively recognized and controlled in Wisconsin since 1917. Its practitioners are registered by the state board of medical examiners after the applicant meets the prequalification requirements outlined in the table appearing at page 14, and, successfully passes an examination conducted by three licensed podiatrists appointed by the board.[105]

The scope of podiatry practice is defined by statute:

> "(1) The practice of podiatry is the diagnosis or mechanical, medical or surgical treatment, or treatment by the use of drugs, of the feet, but does not include major surgery or the use of a general anesthetic. Diagnosis or treatment shall include no portion of the body above the feet except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg insofar as they shall be involved in the conditions of the feet."[106]

Since podiatrists attempted to obtain authorization for the use of narcotics from the legislature and were refused, it is clear that they may not use narcotics.[106a]

Although no one is permitted to practice podiatry unless registered as such by the board of medical examiners, physicians are specifically exempted.[107]

CHIROPRACTIC

The practice of chiropractic has been licensed in Wisconsin since 1925. It has its own licensing board consisting of three chiropractors, appointed by the Governor with the advice and consent of the Senate.[108]

An applicant for chiropractic license must present to the board a certificate of registration in the basic sciences and otherwise meet the prequalification requirements outlined in the table appearing at page 8.[109]

The theory of chiropractic is set forth in rules which have been adopted by the State Board of Examiners in Chiropractic. It is based on the premise that disease or abnormal function is caused by interference with the normal nerve transmission and expression, due primarily to pressure, strain, irritation or tension upon the spinal nerves as they emit from the spinal column, as a result of bony segments, especially of the spine, deviating from their normal juxtaposition.[110]

Limitations on Practice

The practice of chiropractic is defined by board rule. It provides as follows:

> "The practice of chiropractic consists of the analysis of any interference with normal nerve transmission and expression and the correction thereof by a specific adjustment with the hands of the abnormal deviations of the bony articulations especially of the spine, for the removal of the cause of disease, without the use of drugs or surgery. The term, analysis, is construed to include the use of x-ray and other analytical instruments generally used in the practice of chiropractic." [111]

OPTOMETRY

Optometrists are licensed in Wisconsin by a board of five members, appointed by the Governor, and designated the Wisconsin Board of Examiners in Optometry.[113] An applicant for a license in optometry must meet the prequalification requirements outlined in the table appearing at page 8, and successfully pass an examination conducted by the board. No basic science certificate is required. [113]

Limitations on Practice

Optometry is defined as:

> "The practice of optometry is defined as follows: The employment of any means other than drugs to determine the visual efficiency of human eyes or the measurement of the powers or defects of vision; the furnishing, using or employment of any means or device designed or calculated to aid in the selection or fitting of spectacles or eyeglasses; and the adaptation of lenses, prisms and mechanical therapy to aid the vision of any person."[114]

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaptation of lenses, prisms and mechanical therapy for the aid thereof.[115] It is a mechanical trade, not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient. [116]

No one is permitted to practice optometry, as it is defined above, unless he has been licensed by the Board of Examiners in Optometry.[117] Physicians are excepted, however.[118] So too are dispensing opticians to the limited extent that they may take necessary facial measurements and process, fit and adjust mountings, frames, lenses and kindred products in the filling of prescriptions of duly licensed physicians or optometrists for ophthalmic lenses. They may also duplicate or replace lenses without a prescription in those instances where "optometric service" is not required. [119]

ENFORCEMENT OF THE MEDICAL PRACTICE ACT

The obligation of enforcing the Medical Practice Act has been that of the State Board of Medical Examiners for almost 20 years.[120] Enforcement funds are secured from the annual re-registration fee paid to the board by its licensees and registrants.

Both criminal and civil remedies are available to the board. Violations of the Medical Practice Act call for a fine of not less than $100 nor more than $500, or imprisonment for not less than 60 days nor more than one year, or both. [121]

The civil remedy is that of injunction. The board or the District Attorney of the proper county may investigate alleged violations and bring action in the name and in behalf of the State of Wisconsin against a violator to enjoin him from further violations. [122]

CITATIONS

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1959 Wisconsin Statutes as amended by the Laws of 1961. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the Attorney General of Wisconsin.

1. *A History of the AMA,* p. 21
2. Report of Committee on Medical Education, *Transactions of the AMA,* 1848.
3. *A History of the AMA,* p. 22
4. *A History of the AMA,* p. 154
5. *A History of the AMA,* p. 250
6. Chapter 264, Laws of 1897
7. *A History of the AMA,* p. 111
8. Chapter 87, Laws of 1899
9. Chapter 306, Laws of 1901
10. Chapter 431, Laws of 1949
11. Chapter 438, Laws of 1915
12. Chapter 284, Laws of 1925
13. Sec. 147.01 (1), (c)
14. Sec. 147.02
15. Sec. 147.14 (1)
16. Sec. 147.04
17. Sec. 147.02; Sec. 147.19 (1)

18. Sec. 147.02
19. Sec. 147.01 (2)
20. Ibid
21. Sec. 147.02; Sec. 147.19 (2)
22. Sec. 147.02; Sec. 147.19 (1)
23. Sec. 147.02; Sec. 147.19 (1)
24. Sec. 147.09
25. Nickell v. State, 205 Wis. 614
26. 16 Atty. Gen. 560
27. 20 Atty. Gen. 107
28. 21 Atty. Gen. 1135
29. Sec. 147.03
30. Ibid
31. Sec. 147.12
32. Sec. 147.05
33. Sec. 147.06
34. Sec. 147.05; 22 Atty. Gen. 297
35. Sec. 147.06
36. Ibid; Sec. 147.01 (1), (c)
37. Sec. 147.07
38. Sec. 147.06
39. 26 Atty. Gen. 110
40. Sec. 147.08
41. Sec. 147.11
42. Sec. 227.20 (1)
43. Sec. 147.10
44. Sec. 147.21
45. Sec. 147.205
47. Sec. 147.19 (2)
48. Sec. 147.19 (1)
49. Sec. 147.14 (1)
50. Sec. 147.13 (1)
51. Ibid
52. Sec. 147.13 (2)
53. Sec. 147.13 (5)
54. Sec. 147.175
55. Sec. 147.175
56. Sec. 154.04
57. Sec. 147.185 (4)
58. Sec. 147.175 (1), (3)
59. Sec. 147.15
60. Ibid; Wisconsin Administrative Code, Med 1.01–40.08
61. Sec. 147.15
62. Ibid
63. Sec. 147.16
64. Sec. 147.17
65. Ibid
66. Sec. 147.15 (1m)
67. Ibid
68. Sec. 147.15 (2)
69. Ibid
70. Sec. 147.151 (2)
71. Sec. 147.151 (1)
72. Ibid
73. Nickley vs. Eisenberg (1931) 206 Wis. 265, 269–270
74. Sec. 147.20 (2)
75. 12 Atty Gen. 144; State vs. Lewis 164 Wis. 363
76. State vs. Schaeffer, 129 Wis. 459, 467
77. 24 Atty. Gen. 108
78. 18 Atty. Gen. 289; 21 Atty. Gen. 476
79. Sec. 147.20 (3)
80. 18 Atty. Gen. 289
81. 26 Atty. Gen. 378
82. Sec. 147.20 (5)
83. 2 Atty. Gen. 571
84. Sec. 147.20 (4); 22 Atty. Gen. 942
84a. Sec. 147.20 (7)
85. Sec. 147.195
86. Chap. 411, Laws of 1953
87. Sec. 147.185 (6)
88. Sec. 147.185, Statutes 1951
89. Ibid
90. Sec. 147.185 (6)
91. 28 Atty. Gen. 685–686
92. Chap. 411, Laws of 1953; Sec. 147.185
93. Sec. 147.185 (1) (a)
94. Sec. 147.185 (1) (b)
95. Ibid
96. Sec. 147.185 (1) (a)
97. Sec. 147.185 (1) (b)
98. Sec. 147.15 (1)
99. Sec. 147.17 (3)
100. Sec. 147.17 (6)
101. Herzog, Medical Jurisprudence, Sec. 121; and Arnold v. Schmitt 155 Wis. 55, 61
102. 10 Atty. Gen. 837; 29 Atty. Gen. 148
103. 14 Atty. Gen. 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137, 163
104. 29 Atty. Gen. 148, 153
105. Sec. 154.04; Sec. 154.03
106. Sec. 154.01 (1)
106a. Bill 345, A., 1961 Legislature
107. Sec. 154.01 (2)
108. Sec. 147.23 (2)
109. Sec. 147.23 (3)
110. Wisconsin Administrative Code, Chir. 1.14
111. Ibid
112. Sec. 153.03 (1)
113. Sec. 147.01 (2)
114. Sec. 153.01 (1)
115. Sec. 153.01
116. State ex rel Harris vs. Kindy Optical Company, 235 Wis. 498, 501
117. Sec. 153.02 (1)
118. Sec. 153.02 (2)
119. Sec. 153.01 (2)
120. Sec. 147.13 (6)
121. Sec. 147.21
122. Sec. 147.205 (1)

DO YOU EMPLOY FOUR OR MORE PERSONS?

If you do, then you must pay unemployment insurance taxes.

Employers, including physicians, who employ four or more persons for some portion of the day on at least one day in each of 20 weeks in a calendar year are subject to both the state and federal unemployment insurance tax.

The combined state and federal tax is 3% of the first $3,000 of annual wages paid to all employees, of which 2.7% is payable to the state and 0.3% to the federal government.

The report and payment to the federal government is due by January 31 of the subsequent calendar year. Reports and payments to the state are due quarterly during the year in the months of April, July, October, and January. The exact date within the month is set by the state. These reports and payments are due regardless of whether the employer has been notified by either of the governments or has received tax forms.

If a physician or clinic has employed four or more persons in any portion of each of 20 weeks during the current year and has failed to pay the quarterly payments to the state, this should be done promptly so as to keep at a minimum any penalties and interest which will be due. Payment of the federal unemployment insurance tax should be made by January 31.

How to Complete a Death Certificate

The death of a patient requires at least one legal act by the physician. How he does it can be very important.

MOST death certificates are made and signed by a physician. The reason is obvious—most deaths occur with a physician in attendance. This final act by the physician is not a mere routine.

A death certificate is vital in a number of ways. In Wisconsin a human corpse may not be buried or otherwise disposed of before a proper death certificate is made and signed by a competent person. Burial may not take place without a permit for burial or removal. Issuance of the permit depends on a "complete and satisfactory certificate of death."

Here is what the law requires:

1. The certificate shall be made and signed by the physician last in attendance on the deceased.
2. The certificate must specify the time in attendance, the time the physician last saw the deceased alive, and the hour and the day at which death occurred.
3. The physician must state the causes of death in such a way to show the course of disease or sequence of causes resulting in death, and the duration of each.
4. Indefinite and unsatisfactory terms indicating only symptoms of disease or conditions resulting from disease are not acceptable. A certificate containing only such terms will be returned to the physician for correction and definition.
5. The causes of death which may be the result of either disease or violence must be carefully defined. If violence is the cause of death, its nature should be stated, as well as whether it was accidental, suicidal, or homicidal.
6. In case of deaths in hospitals, institutions, or away from home, the physician shall furnish the information required and state where, in his opinion, the disease was contracted.
7. The cause of death and any other facts required must be stated in accordance with the rules and regulations of the State Registrar.

Whoever makes and signs the death certificate must be acquainted with the facts. There may be instances in which the physician last in attendance does not know the cause of death. He may not possess all the information needed to complete a certificate. As a rule, the attending physician does not find it necessary to make a special investigation in order to prepare a certificate. But when a physician is called in to prepare a certificate for a patient he was not attending, he should not insert the information required without first making whatever investigation he feels necessary.

The local registrar may make and sign the certificate if all three of the following conditions are fulfilled:

1. There have been no attending physicians
2. The person desiring to dispose of the body has made request for a burial or removal permit
3. It is impossible to obtain a physician to investigate the cause of death and prepare and execute the certificate "early enough for the purpose."

"Early enough for the purpose" has not been officially interpreted, but it probably means that the local registrar may act in order to prevent an unreasonable delay in funeral ceremonies. If all three conditions are fulfilled, the registrar may make and sign the certificate, utilizing information supplied by relatives of the deceased or other competent lay persons. However, if a physician *may* be obtained he *must* be obtained. Such a physician's services will be paid for by the person seeking disposition of the body. Payment of the physician is reimbursable from the estate of the deceased person as a proper funeral expense.

The coroner may issue a certificate of death:

1. If he has held an inquest on the body
2. Without a formal inquest, if he has investigated a death falling in any of the following specific categories:
   a. Death occurring in a hospital, sanatorium, public or private institution, convalescent home, or the like
   b. Death under unexplained, unusual, or suspicious circumstances
   c. Homicide
   d. Suicide
   e. Death following an abortion
   f. Death due to poisoning, whether homicidal, suicidal, or accidental
   g. Death following accident, whether the injury received was the primary cause of death or not
   h. Death when no physician was in attendance
   i. Death when a physician refuses to sign the death certificate.

REFERENCES

1. Wisconsin Statutes, 1959, Section 69.38–69.41.
2. Wisconsin Statutes, 1959, Section 69.44 (1).
3. 40 O. A. G. (1951) 476.

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

LEGALLY, this concept is generally followed, with Wisconsin statutes and court interpretations becoming rather specific on who may use the title "doctor."

The following is a summary of the present law of Wisconsin as it applies to the right to use the title "doctor" when engaged in "treating the sick" in the state. This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 147.01 (1) of the Wisconsin Statutes, 1959, provide:

> "(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.
>
> (b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 147.14 (3), Wisconsin Statutes, which provides:

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use of Title:	Restricted Right to Public Use of Title:	No Right to Public Use of Title:
1. Physician	X		
2. Osteopath	X		
3. Dentist	X		
4. Podiatrist (Chiropodist)	X		
5. Chiropractor			X
6. Optometrist			X
7. Doctor of Philosophy (when treating the sick)			X

"(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D.," "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 152.02 (1), Wisconsin Statutes, which provides in part:

"(1) Any person who was lawfully engaged in the practice of dentistry in this state on January 1, 1939, may so continue if he has registered annually. . . . No other person shall practice dentistry in this state, unless he is licensed by the board and annually registered in this state. Any person is deemed to be "practicing dentistry" within the meaning of this chapter who . . . uses or permits to be used, directly or indirectly, for a profit or otherwise for himself, or for any other person, the title or appends to his name the words or letters "doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," or "D.M.D.," or any other letters, titles, degrees, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry. . . ."

4. **Podiatrist:** (Chiropodist) The right of a registered podiatrist to use the title without restriction is conferred by Sec. 154.01 (2), Wisconsin Statutes as amended by the Laws of 1961. This provides in part:

"(2) No person shall practice podiatry, for compensation, directly or indirectly, or in the expectation thereof, or attempt to do so, or designate himself as a licensed podiatrist, or use the title "D.S.C.," "Dr.," or "Doctor of Surgical Chiropody," or "Doctor of Podiatry," or "Doctor," or "foot doctor," or "foot specialist" or other title or letter indicating that he is a podiatrist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the state board of medical examiners . . ."

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 147.14 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels,* (1938), 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903, osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O. D." in the course of his practice. Chapter 153 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 147.14 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Doctor of Philosophy:** There is no Wisconsin court decision on the right of a doctor of philosophy to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 147.14 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932), 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 147.14 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

Medical Staff Rules and Regulations as to Sterilizations

SEVERAL INQUIRIES have been received in the past year relating to the legality of surgery for the sterilization of patients. The following opinion, furnished by legal counsel for the State Medical Society, was provided in answer to an inquiry from a hospital chief of staff and relates to the adoption of medical staff rules and regulations concerning surgery for the sterilization of patients. In substance, however, the opinion covers the law on this subject generally.

* * *

The only Wisconsin statute which specifically relates to the procedure to be followed in sterilization cases relates to criminals, the mentally ill and mentally deficient who are in state or county institutions. A copy of that statute, which is Section 46.12, is printed herein in full because it indicates the safeguards with which the Legislature surrounded the sterilization of individuals who are not able to live in a normal way in society. It seems reasonable to anticipate that if the Legislature were to enact legislation covering sterilization in noninstitutional cases, it would provide at least as careful safeguards for the "normal" majority of the public.

Section 46.12, Wisconsin Statutes, 1959:

"46.12 Sterilization of defectives

(1) The department [of public welfare] may appoint a surgeon and a psychiatrist of recognized ability, as experts, who (in conjunction with the superintendents of the state and county institutions who have charge of criminal, mentally ill and mentally deficient persons) shall examine inmates and patients of such institutions as to their mental and physical condition.

(2) The department may submit to the experts and to the superintendent the name of inmates or patients they desire examined, and the experts and the superintendent shall meet, take evidence and examine into the mental and physical condition of the named inmates or patients and report thereon to the department.

(3) If the experts and superintendent unanimously find that procreation is inadvisable the department may authorize an operation for the prevention of procreation.

(4) Before such operation, the department shall give at least 30 days' notice in writing to the husband or wife, parent or guardian of the inmate or patient, if known, and if unknown, to the person with whom such inmate or patient last resided.

(5) The experts shall receive as compensation $10 per day and expenses for the days consumed in the performance of their duties.

(6) The record made upon the examination shall be filed in the department; and semiannually after the operation, the superintendent of the institution where such inmate or patient is confined shall report to the department his condition.

(7) The department shall state in its biennial report the number of operations performed under this section and the result of the operations."

No court decisions have been found in Wisconsin passing on the legal aspects of the sterilization either of institutional or noninstitutional patients. The Attorney General of Wisconsin has ruled on the subject several times, however. In 1932, an Opinion was published, holding, in substance, that even if an institutionalized person were sterilized under all of the safeguards of Section 46.12 of the Wisconsin Statutes, above referred to, there was a serious question, except where the procedure was strictly therapeutic, whether the public officials who requested such surgery and the surgeon who performed the operation were not criminally liable for the common law offense of mayhem, or bodily mutilation.[1]

The Attorney General had ruled four years earlier that an incompetent person could not be legally sterilized except under Section 46.12.[2] The later opinion cited above would thus appear to be an even stricter view.

In 1938, another Opinion of the Attorney General was rendered to the effect that a vasectomy on a person who was not within one of the categories enumerated in Section 46.12 of the Statutes (in other words not in an institution for criminals, the mentally ill or mentally deficient) probably would not subject the surgeon to criminal liability under the mayhem statute if the surgery was performed to benefit the health of the patient. Attention is invited to the careful wording of the final paragraph of the Attorney General's Opinion which stated:

> "We conclude that vasectomy in the instant case *may* be excusable by reason of necessity to preserve health."[3] (Emphasis added.)

It seems clear that a fair reading of the Attorney General's Opinions justifies the conclusion that the Attorney General of this state has taken a consistently conservative attitude toward sterilization surgery whether performed on certain types of institu-

tionalized patients, such as the mentally deficient, or upon normal persons in the ordinary course of private medical practice.

The performance of sterilization surgery for any but clearly therapeutic reasons could subject the surgeon to criminal penalties and to civil liability for damages on suit either of the patient, spouse, parent, or guardian. Mayhem, or bodily mutilation, is a criminal offense under Section 940.21 of the Wisconsin Criminal Code, and is punishable by a fine up to $5,000, imprisonment up to 15 years, or both.

Rules and regulations on this subject should specify the number of consultants in sterilization cases and specify clinical indication for such operation.

It is recommended that at least two physicians be called into consultation before sterilization surgery is performed. That is the number required by Section 46.12 for institutional cases. Under provisions of Rule 14, of the Joint Commission on Accreditation of Hospitals, such a consultant must be well qualified to give an opinion, and a satisfactory consultation would include examination of the patient and his record and a written opinion signed by the consultant and recorded prior to the surgery, except in emergencies. Finally, the same model rule provides that to the extent possible, consultation by physicians associated in the same office should be avoided so as to reduce the likelihood of an assertion that one associate was backing up the other.

As to the enumeration of the clinical indication for such operations for sterilization, this is a matter for determination by the medical staff. An obvious example would be cancer of the reproductive system of a male or female, or the existence of venereal disease in an advanced stage. Additional examples could undoubtedly be procured from medical authorities.

REFERENCES

1. 21 O.A.G. (1932) 940.
2. 17 O.A.G. (1928) 524.
3. 27 O.A.G. (1938) 416.

Legal Opinion on Venapuncture

INFORMATION on the subject of venapuncture was recently requested by a member of the State Medical Society. The following information was prepared by the Society"s legal counsel:

In substance, inquiry has been made as to the legal aspects in Wisconsin relating to the following questions:

(1) Can an intravenous fluid or medicine be administered by a trained student or a graduate nurse when ordered by the attending physician?

(2) Must the attending physician, a resident, or an intern be physically present when a student or graduate nurse begins an intravenous procedure?

We submit our conclusions below but have attached to this letter an appendix which gives a part of the statutory and other authority which are the basis of our position. We conclude that:

1. The puncture of the skin and the entering of a blood vessel is an operative procedure, and as such falls within the definition of the practice of medicine under Wisconsin law. It can be initiated only by a physician, or on his order.

2. The practice of medicine in Wisconsin is permitted to only those licensed for that purpose under Chapter 147 of the statutes. Nurses are not so licensed.

3. An intravenous procedure is not in the category of "general nursing procedures and techniques" which a nurse may execute independent of the supervision or direction of a physician. It is rather a procedure or technique used in the treatment of the sick and as such, it is the legal responsibility of a person licensed to practice medicine and surgery.

4. Since a nurse is not licensed to practice medicine, her acts, except in emergency, must be performed under the general or special supervision or direction of a licensed physician. This principle includes intravenous administration.

5. An intern is not authorized to practice medicine or surgery under Wisconsin law, even though he has completed his formal medical education. Because he is not licensed to practice medicine and surgery, his supervision or direction is not a substitute for that of a licensed physician, including a resident. The latter must be licensed under Wisconsin law.

6. Since a licensed physician is legally and professionally responsible for an intravenous treatment which he ordered for a patient, it is a matter of professional judgment whether he is physically present and in direct supervision of the administration of an intravenous fluid or medicine. If no situation is presented by the patient or the equipment which would appear to require the exercise of professional medical judgment, and the nurse is well trained and experienced, it would appear that a physician need not remain personally present during the administration of an intravenous fluid or medicine. If there is any question of a complication, or even the reasonable likelihood of one, it seems legally advisable that the attending physician, or a resident, initiate the procedure, or be present when it is initiated, that he remain until he is satisfied that the procedure is progressing without complication, that he remain available or issue adequate instructions to cover complications which might reasonably be anticipated.

The above conclusion has reference to such special situations as the patient in shock or in a postoperative period.

Patient's Rights to Medical Records

A RECENT LETTER to the State Medical Society raised a question regarding the legal right of a patient to demand a copy of his medical records. This particular inquiry was whether the patient can legally demand these records, especially where they involved some industrial injury claims. Legal counsel for the State Medical Society has provided this answer because of its general interest to the medical profession and to component medical societies. In 1959, the Wisconsin Legislature enacted Chapter 301, Laws of 1959, which added two subsections to Chapter 269.57 of the Statutes. One of them was subsection (4) which provides as follows:

> "Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs."

Subsequent to the enactment of the above subsection, the State Medical Society and the Wisconsin Hospital Association prepared a joint Interpretation of Chapter 301 which included the subsection quoted in full above. That joint Interpretation was sent to every member of the State Medical Society with a covering letter dated August 2, 1960. (See also page 28 of this issue) It will be the basis of the opinion which follows:

Subsection (4) above quoted obviously relates to the right of access of a patient to physician and hospital records relating to the patient's care and treatment. While it is true that the physician is the owner of medical records which he created and that the hospital is the owner of its records on a patient, the patient has a right of access to the use of relevant records which concern his care and treatment.

Before complying with the request, it is suggested that the physician confer, if practical, with the patient to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain *who* suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

This procedure is suggested because the applicable statute of limitations may not run for as long as the period for which the patient has requested records.

Once the decision has been made as to how far back to go and just what portions of the total medical record are to be copied, the physician should *not* let the record leave the clinic premises. Further, he should *not* permit anyone outside his staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician might lose a portion of the record if he does not observe these precautions, and such loss could prove a handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the Interpretation of Chapter 301, Laws of 1959, which members of the State Medical Society received last year. The physician or anyone designated by him to handle this matter would do well to review the contents of the Interpretation *before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a written authorization signed by the patient; and the physician should be satisfied (1) that the signature is the patient's, (2) that he is mentally competent to make the request, and (3) that the information is not of a character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that he was his physician and has a continuing responsibility toward him for the period of such care and treatment.

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

Inspection of Physician and Hospital Records

An Interpretation of Chapter 301; Laws of 1959

by the

STATE MEDICAL SOCIETY OF WISCONSIN and the WISCONSIN HOSPITAL ASSOCIATION

August, 1960

Introduction

Chapter 301 as passed by the 1959 Wisconsin Legislature and signed by the Governor, created Subsections (3) and (4) of Section 269.57, Laws of Wisconsin. The new subsections affect the right of access to physician and hospital records relating to patient care.

It is generally agreed that physical ownership of medical and hospital records rests with the physician and the hospital. However, since the doctor-patient-hospital relationship is a contractual one, the patient has a right of access to relevant records concerning his care and treatment.

Because physicians, patients, hospital staff personnel and others are not clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes the "hospital record," representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an interpretation of this subject.

Upon the recommendation of attorneys for the State Medical Society of Wisconsin and the Wisconsin Hospital Association, approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association, the following recommendations and suggestions regarding the hospitals' and physicians' responsibilities under Chapter 301, Laws of Wisconsin, 1959, have been prepared as a guide:

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1. Upon being presented with an authorization form for the inspection of medical records, physicians and hospitals must assure themselves that the patient did *in fact* sign the authorization, and that he was of *legal age* and had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian, and the hospital or physician must take such precautions as are necessary to satisfy themselves that those signing are thereby authorized to effect the release of the records of the patient.

The hospital or physician must be assured that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any prudent or reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the hospital administrator, or his representative, or the physician, depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the mental capacity of the patient or as to the authenticity of his signature.

On being satisfied that the authorization presented is properly signed, as previously outlined, and that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the hospital, institution or physician to permit such person to inspect and copy "medical or hospital reports, photographs, records, papers and writings" concerning the care and treatment of such patient.

It is first necessary to determine what must be made available for inspection and/or copying. It is believed that under a strict interpretation of subsection (4) of the statute, the physician's records (office or hospital), and the hospital clinical record or chart should be presented. In the case of x-rays there seems to be some disagreement among legal authorities that they are part of the medical record as such or are technically photographs. It is advised that x-rays *not* be released unless by court order, and that they be inspected *only* under proper supervision (in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator; in the case of a physician's office, by the physician in charge, an associate, or the designee of either).

Administrators and physicians should be cautioned that the copies of the records should be made only under properly authorized supervision, and

that the originals of the records cannot be taken out of their custody at any time *except* under court order.

To avoid substantial wasted administrative or professional time with the examination and copying of records relating to illnesses which do not fall within the inquiry of the patient, it is strongly urged that the administrator or physician request that the illness and the period of time both be specified in the written authorization, or be agreed to by the person presenting such consent.

2. One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional reponsibility of the attending physician and of those acting under him. The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her acts or observations made pursuant to special or standing orders, is one which relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute.

Consistent with the above conclusion, it is believed (1) the notes of the attending physician, consultants, and of a resident, plus (2) the patient's chart, are *all* that make up the official hospital record. X-rays have been treated earlier in recommendation 1 herein. Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, or are not licensed to practice medicine, and are not recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic records relating to the care or treatment of the patient.

There has been understandable apprehension on the part of some hospital administrators and physicians that the production for inspection or copying of nurses' notes, or of comments by interns, social workers, and others, could embarrass or damage the interests of the patient, the hospital, or the attending physician. It is emphatically recommended that medical staffs and hospital administrators embark on an immediate, intensive, and continuing program of education which has as its sole purpose the maintenance of patient records which are limited to physical findings, diagnosis, treatment, prognosis, and to acts or observations made in the course thereof, or made pursuant to standing or special orders. If medical staffs, nursing staffs, and personnel under training, will so limit what they write, whether as part of the official patient record, or as part of an educational record, such apprehensions will disappear.

Again, emphasis should be placed on the importance of *physically separating* writings relating to a patient into (1) those made by or under the authority of the attending physician, consultant, or resident, and (2) those made for educational, training, internal, or other collateral purposes. The two categories of writings should be *separated* when

NOTE

Chapter 301, Laws of 1959, as passed by the 1959 Wisconsin Legislature and signed by the Governor, created the following subsections to Section 269.57, Wisconsin Statutes, 1959:

269.57 (3) No evidence obtained by an adverse party by a court-ordered physical examination or inspection under sub. (2) shall be admitted upon the trial or by reference or otherwise unless true copies of all reports, photographs, records, papers and writings made as a result of such examination or inspection and received by such adverse party have been delivered to the party claiming damages or his attorney not later than 15 days after the said reports, photographs, records, papers or writings from any such court-ordered physical examination are received by the said adverse party, provided that in an action for recovery of personal injuries, the party claiming damages shall in return deliver to the adverse party against whom the action is brought a true and correct copy of all reports of each physician who has examined or treated such person with respect to the injuries for which damages are claimed.

(4) Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, the physician, surgeon or other person having custody of any medical or hospital reports, photographs, records, papers and writings concerning such care or treatment shall forthwith permit the person designated in such authorization to inspect and copy such records. Any person having the custody of such records who refuses to comply with such authorization shall be liable to the person receiving such medical care and treatment for all reasonable and necessary costs of obtaining such copies and inspection and for attorney's fees not to exceed $50 plus costs.

The 1961 session of the legislature enacted two laws adding two subsection (5)'s to this law. Since both acts refer to the same subsection, a revisor's correction bill has been put in to correct the error. This bill has passed both houses of the legislature, but has not yet been signed by the Governor. As there seems little doubt that the Governor will sign the bill, set forth below, you will find the new law as corrected by the revisor's bill.

"269.57 (5) The provisions of sub. (4) shall not be applicable to state or county mental hospitals, or to state colony and training schools, or to community mental health clinics established pursuant to s. 51.36."

CONSENT TO EXAMINATION OF PHYSICIAN'S RECORDS

To Dr. _____

I hereby authorize and request you to furnish a copy of the medical records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by _____

_____. I hereby release you from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

CONSENT TO ACCESS TO HOSPITAL RECORDS

o _____, Hospital Administrator, _____ Hospital.

I hereby authorize you to furnish a copy of the hospital records of _____

_____, covering the period from _____ 19____ to
(State name of patient or "myself")

_____ 19____ or to allow those records to be inspected or copied by _____

_____. I hereby release _____ Hospital and you personally from all legal responsibility or liability that may arise from the act I have authorized above.

Signed _____

Witness _____ Date _____

the patient is *discharged* from the hospital, since only the first of them relates to the "medical care or treatment" of the patient, and is the only type of record called for by the new statute, and the only type which the physician or hospital should present for inspection or copying.

3. If an authorized person demands more than the above, it should be *refused* and a court allowed to rule on the request. If hospital administrators, physicians, and interested members of the public cannot determine what is embraced in the phrase "medical or hospital reports" relating to the "care or treatment" of the patient, a judicial determination of this question may well become necessary and even desirable.

4. It is further believed that the authorization to inspect and to copy is *personal* to the patient, and for that reason *does not survive* his death. Thus an authorization signed by an executor, administrator or member of a deceased patient's family has no legal effect under subsection (4) of the statute.

5. The potential liability of a hospital for defamation, and the statutory liability of the physician for "wilful disclosure" of professional secrets, deserve brief comment. Both are under the primary duty of not permitting the operation of the statute to be broader than its wording.

Section 269.57 (4) does *not* in words or by implication, give a right to remove any records from the hospital, institution, or a physician's office, the records being the property of the hospital, institution or physician.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on in the presence of a custodian (hospital or physician), or the representative of either. The statute does not require a hospital, institution, or physician to copy any records at the request of a patient or his representative. If a request is made by a patient or his representative, and the request is granted, the hospital, institution, or physician making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

6. Few people, other than medically trained personnel, will know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

7. The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but "as soon as the convenience of an administrator, a record librarian, or a physician, *reasonably* permits," after taking into account the urgency of prior demands on their time and personnel, and whether advance notice had been given of the demand of the particular patient.

8. When there is any indication that legal proceedings may ensue, the hospital, institution or physician served with a proper demand to examine or copy a patient's records should promptly notify its insurance carrier of this fact, and also the general attorney of the hospital, institution or physician. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such demand be given by the person receiving same to the other interested parties.

Since no wording appears in the statute prescribing the form for authorization to inspect and copy a patient's records, a model form is not being recommended. It is believed that authorized persons, be they attorneys, insurance adjusters, relatives, or others will familiarize themselves with the statute and will prepare their own authorization. However, as a suggested guide for hospitals and physicians, there are sample forms attached which generally meet the requirements set forth in recommendation No. 1 herein. It is not to be construed as a model authorization form, but merely as a suggested guide.

FIRST ANNUAL ESSAY CONTEST—NATIONAL GERIATRICS SOCIETY

Wisconsin physicians are invited to participate in the first annual essay contest offered by the National Geriatrics Society. Subject is "Institutional Care of the Aged." All papers are to be judged anonymously. Identification numbers may be obtained from the office of the President, P. O. Box 2605, Niles, California. Awards: First—$500; Sixth—$100. Deadline: March 15, 1962.

Areas of Service of Wisconsin Institutions for Mentally Ill, Infirm and Retarded

A CONSIDERABLE number of patients enter Wisconsin mental hygiene institutions each year as voluntary patients. These patients, or their relatives, may make most of their own arrangements and arrive at an institution requesting admission only to find that they have come to the wrong institution and will not be admitted. When this happens it becomes necessary that they make new arrangements to go to the institution to which they are eligible.

The Statutes (Section 51.05) provide that the Department of Public Welfare determine the areas of the state which shall be serviced by the institutions for mentally ill and infirm. The Department has done this and has held quite rigidly to the admission of only their patients who live in the district in which the hospital is located. This has been necessary in order to control the population at each of the institutions.

The family physician referring the patient to an institution can help individuals and their families by saving them from the inconvenience of travel to the wrong institution.

State Hospital Districts for Mentally Ill or Infirm

Patients may be admitted to Mendota or Winnebago State Hospitals either by court commitment or by voluntary admission. In general, patients from eastern Wisconsin (except in Milwaukee County) can enter Winnebago State Hospital and those from western Wisconsin, Mendota. The eastern and western districts are shown by heavy solid line on the accompanying map.

State Colonies for Mentally Retarded

Mentally retarded patients from northern Wisconsin are normally received at the Northern Colony and Training School at Chippewa Falls, whereas those from southern Wisconsin are received at the Southern Colony and Training School at Union Grove. At the present time there are no districts officially designated by the Department of Public Welfare for the purpose of allocating areas of service for the two colonies but unofficially the heavy dotted line on the map shows districting presently being contemplated.

Prepared by the Division of Mental Hygiene, State Department of Public Welfare.

Restriction of Admission to Institutions for Mentally Retarded

The admission of patients to Wisconsin's institutions for the mentally retarded may be by commitment (Wisconsin Statute 51.05 (1)) or by voluntary application at the discretion of the Superintendent (Wisconsin Statute 51.10 (1)). The voluntary application in the case of the mentally retarded must be supported by a physician's certificate just as with the mentally ill.

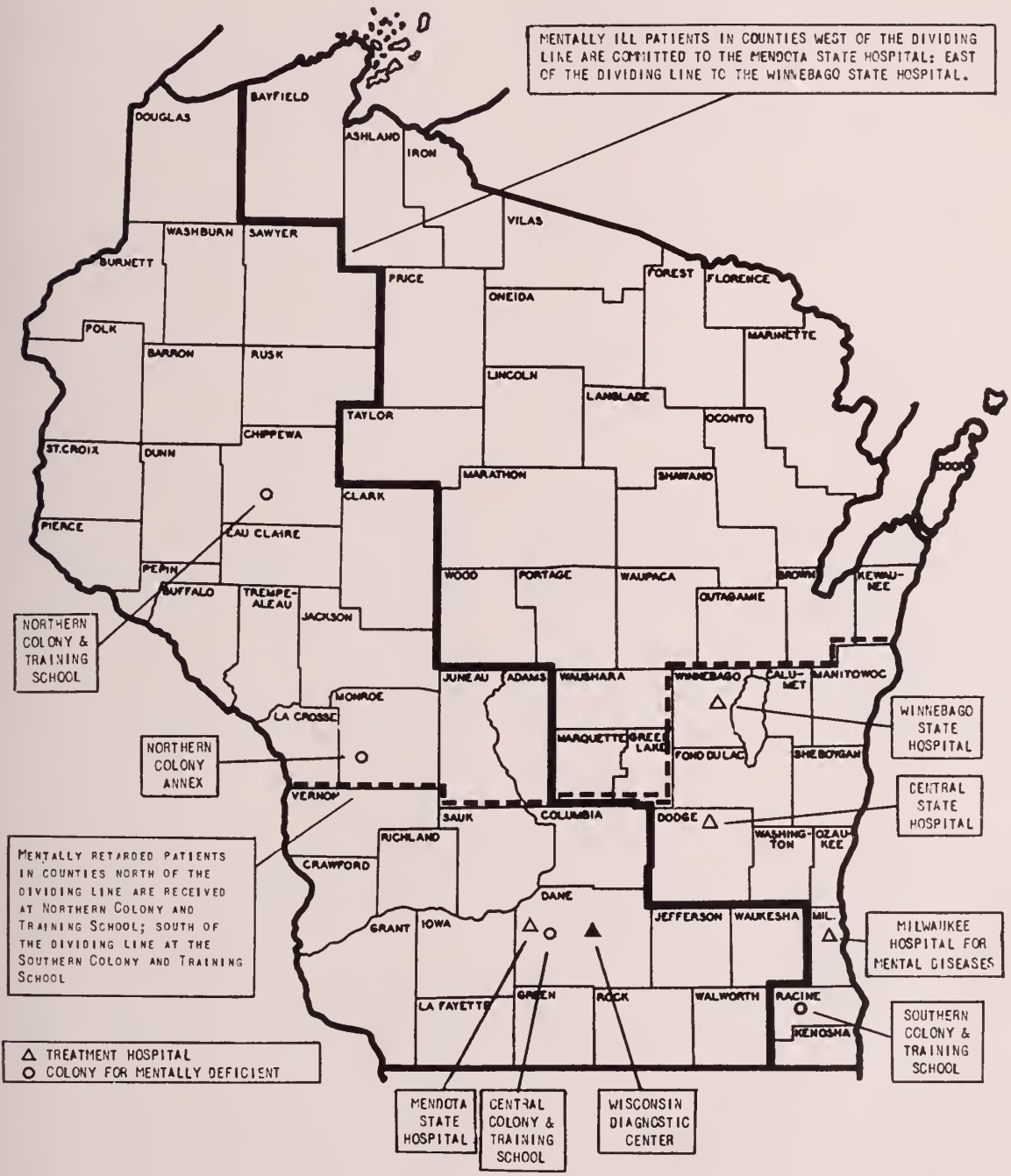
Although voluntary admission at the discretion of the Superintendent is possible by Statute and is considered a desirable procedure for admission to an institution for the mentally retarded, it is not now used in practice. The main reason for this is the serious degree of overcrowding in the institutions and the waiting list of committed persons awaiting admission.

At the end of November 1961 Northern Wisconsin Colony and Training School at Chippewa Falls with a rated bed capacity of 1,123 had 1,649 patients in the institution. Southern Wisconsin Colony and Training School at Union Grove with a rated bed capacity of 1,091 had 1,439 patients. The combined waiting list was 341 for the two institutions on October 31, 1961.

Central Wisconsin Colony and Training School at Madison has been operating for two and a half years. The first two units of that institution have been filled to their capacity since shortly after the opening. The nursing building, completed and dedicated during the summer of 1960, is being gradually occupied. All admissions to Central Colony are by transfer from the Northern and Southern Colonies. Progressive occupation of this facility has been slowed down by a serious shortage of graduate nurses. Despite that shortage they are only about six weeks behind their anticipated schedule of admitting patients.

In helping parents to make their own decision about referral of a retarded person for institutional care it is especially important because of the crowding and the waiting list to be sure the retarded person, in addition to being retarded, is in need of the specific care which the institution can provide. It is also important to consider with them the fact that a fairly long waiting period may be involved before they make a final decision as to their interest in institutional care for their child or relative.

STATE MENTAL INSTITUTIONS IN WISCONSIN



Some of Your Income Can be Taxed At Only 20 Per Cent

Ten examples show you how the short term trust works

THE tax laws do contain some provisions which allow high income taxpayers to escape or reduce income taxes. The short term trust is one of these. Its use allows a high bracket taxpayer to rid himself of his most heavily taxed income in his highest income earning years. By creating a trust for 10 or more years the income non-taxed at the physician's top rate is taxed instead to a lower bracket trust or beneficiary. Then, in later years when your income is lower, you get your property back and the right to the income from it.

Here is a partial list of what you can accomplish for your family by setting up a short term trust:

(1) build a retirement fund
(2) build an educational fund for children
(3) support dependent relatives
(4) set up a son's business or provide daughter's dowry
(5) purchase life insurance for children
(6) build funds to insure liquidity of your estate upon your death
(7) transfer assets to grandchildren
(8) purchase real estate
(9) shift capital gains
(10) fund purchase of partner's business for benefit of son.

What you do is simply turn over income producing property to a trust which you create by a written agreement between you and a trustee. The trust must last for 10 or more years. The agreement can permit the trustee to accumulate the income during the 10 year or longer period and then distribute it to beneficiaries named in the agreement, or it can be distributed to them currently each year. It will be taxed to the trust if the income is accumulated or to the beneficiary if distributed currently. At the end of the period of the trust, the property comes back to you and you again become entitled to the income.

Setting up a trust is a gift for gift tax purposes. But if the trust is to last 10 years the value of the 10 year gift is only about 30% of the value of the property. Furthermore, most taxpayers haven't used up their lifetime federal gift tax exemption of $30,000. So the gift tax should not be too much of a problem to most taxpayers.

You'll need a lawyer to set up your trust and quite probably you'll want to discuss it with your accountant and investment broker as well as a bank trust officer.

Illustrations of Income Tax Savings Possible

Taxable Income of Creator of Trust:	*Tax Savings if Trust is Taxed and Property Produces Annually:*				*Tax Savings if Beneficiary* is Taxed and Property Produces Annually:*			
	$1000	*$2000*	*$3000*	*$5000*	*$1000*	*$2000*	*$3000*	*$5000*
$10,000	$ 80	$140	$ 142	$ 106	$198	$278	$ 313	$ 362
14,000	120	220	262	306	238	358	433	562
18,000	160	300	382	506	278	438	553	762
20,000	160	300	422	586	278	438	593	842
24,000	200	380	542	786	318	518	713	1042
28,000	250	480	692	1026	368	618	863	1282
32,000	290	560	812	1236	408	698	982	1492
50,000	410	800	1172	1876	528	938	1343	2132

* Assumes Beneficiary has no other income.

Examples of How the Short Term Trust Works:

1. Retirement Fund or Deferred Compensation Plan

You *can't* set up a short term trust for *your own* benefit. But there is nothing to prevent you from setting one up for your wife. You don't want the income paid out currently to your wife because that would cause it to be taxed at the same high rates applicable when you and your wife file joint returns. So you give the trustee the discretion to accumulate the income for her. It is then taxed to the trust at the 20% or 22% rates. At the end of the term of the trust the income is paid to your wife and she then helps support you and your family out of this fund.

If you are a 50% bracket taxpayer and you put $50,000 of securities paying an average of 4% annual return, you can annually build up a retirement fund from income tax savings alone of about $600.00. Assuming the trustee reinvests this saving during a 15 year period a fund of approximately $12,000 will have been built up just out of the tax savings. And you get back your $50,000, plus any principal growth, at the end of the 15 years.

Put another way, the trust can build up a fund, *after taxes*, of about $30,000 during the 15 year period. To have built a similar $30,000 fund with your 50% post tax dollars you would have needed to invest a fund of $85,000 instead of the $50,000. At the end of the 15 years, your wife can take the $30,000 and invest it, spend it, or buy an annuity.

2. Education Fund for Children

Many parents set aside funds annually for their children's college education. If you are a 50% taxpayer it takes $2,000 of income to set aside $1,000 for your children's education. Instead, if your children are young enough so that the 10-year minimum period of a trust ends before their education is completed, you can put income producing assets into a trust which accumulates the income and distributes it to your children at the end of the 10 years. They can then use it for their education. Doing it this way requires about $1,200 annual earnings to set aside the same $1,000.

You must be careful not to have the income used for the support or education of your children while it is still in trust. If this is done, the income will nonetheless be taxed to you. In our illustration, the income is *not* used until the trust is ended, so there is no problem.

During the period of the trust, the income could be reinvested in other securities or in endowment or life insurance policies payable or cashable at the end of 10 years.

You can even cut down the 20% tax payable on income earned by a trust for the benefit of your children if the trust can pay out to the children up to $599 annually. This amount could be put into a savings account for each child. The $599 paid out annually would escape tax entirely because it is less than the $600 exemption of your child.

3. Dependent Relative's Support

A short term trust can save you money if you are supporting a relative whom you have no legal obligation to support. A mother-in-law, or brother or sister are examples.

Assume you give your mother-in-law $200 a month to live on and that you are in the 50% bracket. This requires $400 of pre-tax monthly income. If your mother-in-law has no taxable income of her own, you can set up a trust paying her $200 per month for 10 years, or her lifetime, whichever is the lesser, and save yourself about $2,400 a year in income tax.

You would lose the exemption of $600 for your mother-in-law, but this would merely reduce your $2,400 tax saving by $300.

4. Increasing your Estate's Liquidity

Income from a trust you set up can't be used to pay premiums on policies insuring *your life*. But there is nothing to prevent your wife from using *her funds* to create a trust to pay premiums on life insurance on your life. The beneficiary of this trust created by your wife could be your children. You could empower the trustee, in the event of your death, to use the life insurance proceeds collected by it to purchase non-liquid assets from your estate. Thus you would have the life insurance cash available to your estate. Through this perfectly legal device you can get almost double the amount of insurance purchased for the same amount of pre-tax dollars.

5. Purchase of Life Insurance for Children

If you wish to get your son or daughter started in a life insurance program so as to get the benefit of low premium rates, consider payment of these premiums through a short term trust.

The trust can do it cheaper than you can because it is being done with low taxed dollars.

If you wanted to transfer a $25,000 paid-up policy to your 11-year-old son when he reached the age of 21, you could transfer $35,000 of 4% securities to a trust and the post tax income would be enough to finance a 10 pay life policy. If you are a 50% taxpayer it would have taken $70,000 of securities to produce enough after tax dollars to do the same thing.

Fewer funds, of course, need be put into the trust if you wish to finance lower premium policies during your child's minority such as an ordinary life policy.

6. Using Borrowed Funds to Set Up a Trust

Tax-wise it would be advantageous to you to borrow money and place the loan proceeds in a short term trust.

Assume that you could borrow $100,000 at 5% for 10 years and that you were in a 50% tax bracket. Because you now have an interest deduction, you have actually cut your income tax by $2,500 annually, so the $5,000 interest you pay will only cost you $2,500. The trust will have annual income of $5,000 if it also earns 5%, on which it will pay a tax of $1,074, but $3,926 of income, plus the income on reinvestment, can be accumulated annually for designated beneficiaries. At the end of the 10 years you get the $100,000 back plus any principal growth and you can repay the loan. Subtracting the interest cost to you of $2,500, the $3,926 nets out at an annual gain of $1,426.

This arrangement could be varied for purposes of buying or building a medical arts building or other rental property. You could borrow money to buy or erect the building and then transfer the building to a trust. If it is a medical arts building, you could lease it back from the trust. You must continue to pay the principal and interest installments on the mortgage rather than the trust; otherwise you will be taxed to the extent trust income is so used.

7. Grandfather Trusts

If you are a grandfather and want to protect your son's wife and children against the untimely death of your son in the years when he is getting started, you can do it advantageously with short term trusts for the benefit of your grandchildren and daughter-in-law set up to finance life insurance on your son's life. At the end of the 10 or 15 years, your son ought to be in a position to continue the premiums himself.

8. Shifting Capital Gains

If for example, you have property presently worth $10,000 that is expected to multiply in value in a few years, you can divert the capital gains tax from yourself to a trust or its beneficiary, with a substantial resultant saving.

9. Setting up a Son's Business, or Helping Out Newlyweds

Today many adult sons and daughters need help in the early years of their marriage or business careers. You can provide through short term trusts the same help with much less dollar outlay.

Suppose your daughter is 21 years of age and about to be married to a medical student and that you are in the 50% bracket. Suppose further you want to give her $1,000 a year. You can transfer securities or income property to a trust which pays all the income to her.

If you give her this out of your own pocket it is costing you $2,000 a year of income because you first must pay Uncle Sam $1,000 of tax.

If, on the other hand, you set up a trust for her benefit and transfer into it securities producing $1,000 of income, your daughter will still be receiving the $1,000. You, however, will actually be increasing your spendable income by $500! This is so because you have cut your income by $1,000 thus saving half of this in income tax. True, your income is also down by $1,000 but this is offset by your not having to give your daughter $1,000 any longer.

Typically your daughter will have little or no tax to pay, so this will be no deterrent.

10. Purchase of Partner's Business for Benefit of Son

If you have a son interested in coming into a partnership with you, and your partner had no son interested in doing likewise, purchase of life insurance on your partner's life can be advantageous to all concerned.

If a partnership buy and sell agreement were set up to allow your son to buy out your partner's interest at his death, the insurance on the partner's life necessary to fund the purchase could be financed by means of a short term trust set up by you, taxed at 20%.

* * *

These trusts are recognized under Wisconsin income tax laws as well. While the foregoing examples are only of federal tax savings, considering Wisconsin will only increase the total tax savings.

* * *

Remember that short term trusts lasting for 10 or more years are primarily income tax savers. If you should die during the term of the trust, some death taxes would be saved depending on whether death occurred early or late in the term.

Remember, too, that the creation of a trust is a gift of the right to receive the income for the term of the trust. Its creation may or may not result in a gift tax being payable.

Remember that setting up these trusts requires expert tax advice from a lawyer and accountant.

Nine Questions about Your Professional Liability Insurance

OF COURSE, you have a professional liability insurance policy to protect yourself, your property, and your future against the hazards of malpractice claims. But, are you as well insured as you want to be, or even think you are?

Your malpractice policy does not cover all risks, and there is no good reason why it should. If it did, you undoubtedly would be paying premiums for coverage you don't need.

The important thing is for you to insure against the risks you are exposed to in your particular practice. It will be worth your while to examine your present policy with that thought in mind, and periodically to re-examine it with an eye to keeping it in line with your practice as it develops.

The following nine questions and accompanying comments will make it easier to conduct the examination. They all deal with *your* policy, and one or two of them may suggest a need for further attention.

1. Will your company be strong financially for the next twenty-five years or more?

Your malpractice policy is no better than the company that stands behind it at the time a claim becomes collectible. The adult you treat today may wait for three years (under the present Wisconsin statute of limitations) to start a lawsuit alleging malpractice in today's treatment. The infant you deliver today may start his action as late as the day before his twenty-second birthday.

It isn't the policy you hold on the day of suit or of judgment that will protect you on what you do today. You must rely *then* on the company that insures you *now*, and if, by *then*, it lacks the money to cover a claim, you do not have *now* the full measure of insurance your policy describes.

That a financial forecast covering a quarter of a century can not be very reliable goes without saying, but it also goes without saying that the place to begin in evaluating your professional liability policy is with the prospects of your insurance company for long-term solvency.

2. Are your policy limits high enough?

You can never be sure of striking the ideal balance between premium economy and adequate policy limits, but it is more comfortable and less costly to have more insurance than you need than to need more than you have.

Your professional liability policy provides two kinds of coverage. The company agrees to pay, up to policy limits, the amount of damages you may become liable for as a result of malpractice. The company also agrees to defend you against suits for such damages.

The first of these coverages has the effect of protecting your property against loss to the successful malpractice claimant. For this reason, the more prosperous you are and the better your prospects for future prosperity, the stronger are your motives for carrying high policy limits. In particular, you will keep in mind that today's limits protect tomorrow's estate.

The second coverage, which gives the company the financial burden of conducting your defense against the malpractice claimant, may help you vindicate, and thus protect, your professional reputation. A verdict in your favor can do much to restore the confidence in your skill and judgment that the news of a suit against you may undermine.

Policy limits have no direct bearing on the second coverage, since the cost of a vigorous defense is not applied toward the exhaustion of those limits. But, they do have an indirect bearing in some cases, as the following examples will show.

First, take the case of a $5,000 claim which the company considers entirely without merit. The company will conduct as vigorous a defense under a $10,000 policy as under one for $100,000. It is the company's $5,000 that will be saved by defeating the claim.

But now take the case of a $25,000 claim, a $10,000 policy, and a defense that your company appraises as uncertain. The company may welcome the opportunity to spare itself the cost of litigation by paying out its full $10,000 liability. Had the policy limits been $25,000, the company may still have preferred to settle the claim for $10,000 to $15,000, but if the claimant rejected such offers, the company might then decide to gamble on the uncertain defense rather than pay the $25,000 without a fight. If the defense actually prevails, the company will save its money and, incidentally, may also save your professional reputation. This incidental effect is the important one for you, but the risk of litigation to achieve it would be yours if low policy limits protected the company's purse, instead of yours,

against payment of an exorbitant, but doubtful, claim.

3. Does your policy permit you, without penalty, to veto claim settlements which seem expedient to the company but not to you?

Some professional liability policies permit the company to decide between litigation or compromise of a claim. Most policies, however, permit the physician to participate in this decision, by reserving the right of settlement to the company "with the written consent of the insured." Such policies, in effect, give the physician the power to veto settlement when he believes defense is in order.

You should examine your policy to determine whether you have any control over the settling of claims, and if so, whether your exercise of that control may result in a forfeiture of some part of your insurance. For example, one policy permits the physician to veto a settlement offer recommended by the company, but automatically limits the insurance coverage to the amount of the offer if the physician vetoes it.

How important such provisions are in your policy depends on the relative importance you attach to its two kinds of coverage. If you only want the company to protect your property by paying claims, you will be willing to have the company settle any claim as it pleases within the limits of the policy. But, if you are also interested in having the company defend your professional reputation against the assaults of the malpractice claimant, a policy that denies you a voice on the subject of compromise will not be entirely to your liking. Nor will you be much better pleased with a policy that, in effect, reduces its limits to something less than you bought if you presume to reject a compromise.

Of course, even if your policy does give you an unrestricted veto on settlements recommended by your company, you will exercise it with restraint, weighing carefully the company's views, and considering the greater damage to your professional reputation if you lose at trial.

4. Does your policy protect you for all the specific procedures and forms of treatment you employ in your practice?

Nearly all malpractice insurance policies start out with an insuring clause expansively stating the company's promise to pay on the insured's behalf all sums he may become legally obligated to pay as damages because of injury arising out of malpractice, error or mistake in rendering or failing to render professional services in the practice of the insured's profession. Typically, the expansiveness of this promise is then reduced by restrictive provisions appearing elsewhere in the policy.

The policy "exclusions" are the most obvious provisions to check for restrictions that may remove important phases of your professional practice from coverage.

A long list of exclusions should increase rather than decrease your faith in the policy you hold. It may be a sign that your company is not wasting your premium dollars by paying claims in risk areas where you have no exposure.

What you want to determine is whether anything listed as an exclusion constitutes a risk on which you do have an exposure. For example, if cosmetic plastic surgery is included in your practice, and your policy excludes it from coverage, you can probably buy, for an additional premium, a policy endorsement removing the exclusion. If your company won't sell you such an endorsement, you will want to investigate the possibility of a new policy without such a restriction. The same approach is indicated for any specific procedure, set of procedures, or form of treatment that your practice includes but your policy excludes.

5. Does your policy protect you against claims based on defects in any apparatus you use?

You will want to check your equipment and apparatus as well as your procedures and forms of treatment against your policy exclusions. Again, you will buy additional or new insurance if you find a gap in coverage.

6. Does your policy protect you for your acts which, though outside the immediate scope of your practice, are within the general area of your professional competence and activity?

Perhaps your competence as a physician has led you into one or more areas of activity apart from your professional practice. Perhaps you could cause an injury and become liable for damages as a result of such activity. The question is whether your professional liability policy covers the risk.

If, for example, you are the proprietor or other official of a hospital, and your policy specifically excludes coverage for any liability you may incur in such a capacity, the question is easy to answer and your course of action is clear. You will want an endorsement to your policy, or a new policy, specifically covering the excluded risk. Or you will want to make sure that the hospital has a satisfactory liability policy, one that covers not only the hospital's liability for your acts, but also your own liability for them. Don't be satisfied with a policy for the hospital if the insurance company might sue to recover from you what it pays out to discharge the hospital's liability for your acts. That arrangement would give you no protection.

But, suppose you engage in an activity other than professional practice, and your professional liability policy makes no mention of that activity. The question of coverage in that case is not so easy to

answer, and instead of guessing, the safe thing for you to do is to give your company written notice describing the activity and requesting a commitment to cover its risk. If the company will not commit itself, you will take the same precautionary measure as if your policy had contained a specific exclusion on the matter. You will enter the market for the adequate insurance you need.

7. Does your policy let the company decide the question of coverage when a claim accuses you of misconduct which, if proved, would not only establish the claimant's case against you but also relieve the company of its liability for you?

Your professional liability policy probably excludes coverage for injuries arising from criminal acts or from the acts of any person under the influence of an intoxicant or narcotic. With or without a formal exclusion, it will not cover for liability you may assume under an agreement guaranteeing the result of any treatment. Failure to deliver on such a guarantee is breach of contract and not malpractice; it is not within the scope of malpractice insurance.

You will be pleased to know that these things are not covered, and that your premiums are not being used to underwrite quackery, gross negligence or crime.

But, what if a patient falsely charges that you injured him in the course of treatment and were intoxicated or engaged in a criminal act at the time? Though, under the policy exclusions, you would not expect your insurance company to assume any liability on your behalf for damages, the question is whether the company will disclaim all responsibility for the conduct of your defense. If the patient's charge were true, there would be no coverage whatsoever. But if, prior to verdict, the company denied coverage for defense in the suit, the denial would amount to a presumption of your guilt pending proof of your innocence.

Your policy may or may not contain clear cut language defining the company's options in ambiguous situations of this kind. For example, it may permit the company to decide the question of suit coverage unilaterally; or it may contain an outright denial of coverage for defense when the claim asserts conduct falling within any exclusion. On the other hand, it may leave the question of defense coverage open until the basis for the exclusion has been definitely established. Probably no policy is wholly satisfactory on this point.

Perhaps the most important thing to keep in mind about a case presenting the question not only of liability to the claimant, but also of coverage by your insurer, is that you should have independent legal counsel of your own and should not rely entirely on your insurance company. In a case of this kind, your interests and the company's may be in serious conflict.

8. Does your policy protect you against claims based on the acts of other persons?

Not only your own acts, but also the acts of any employees or partners you have, may give rise to malpractice claims against you. You will want to make sure that your professional liability policy protects you no matter who commits the act.

Most policies specifically state that the coverage protects the person insured for malpractice, error or mistake in rendering or failing to render professional services in the practice of the insured's profession described in the declarations, committed during the policy period of the insured "by any person for whose acts or omissions the insured is legally responsible except as a member of a partnership." The first thirteen of the above quoted words automatically take care of your liability for the acts of your employees. The same thirteen words would also take care of your liability for the acts of your partner if it were not for the exception expressed by the concluding seven words.

For additional premium, your company will doubtlessly issue an endorsement to your policy insuring you for the act of any partner to the extent that he himself fails to satisfy a malpractice claim for which he is directly liable, subject, of course, to the limits of your own policy.

If you have employees, you should check your policy for language substantially like that already quoted. If you have one or more partners, either you should be absolutely certain that each one keeps himself insured to limits as high as those you deem prudent for yourself, or else you should invest in insurance for yourself against your liability for his acts.

9. Are the "declarations" in your policy correct?

Some of the earlier questions and comments in this article may have brought home the fact that your own professional liability insurance needs may differ from those of other physicians. Their risks may be greater or less than yours, and so also the premium charges made for the insurance you and they may carry.

In fact, it is quite possible for two physicians to have policies with the same company containing the same standard provisions and special endorsements, and still differ with respect to the actual insurance each has and the premium each pays. The reason is that the policy "declarations" may differ for the two men.

The declarations in your policy not only state your name, the fact that you are a physician, and the cash limits of the company's liability, but also may contain some detail about the manner in which you practice. To the extent that it does, it describes

the risk that your company agrees to insure. If there is a discrepancy between the facts and what the "declarations" state, you may find to your regret when a claim arises that the company's agreement does not cover your situation. Your insurance may be void.

Obviously then, you should have any errors you find in the declarations corrected immediately. Moreover, you should have the declarations revised to the extent necessary as often as your practice undergoes any change. Care in these matters provides insurance against loss of insurance.

PREPRINTED PRESCRIPTION BLANKS

The Narcotics Bureau of the Internal Revenue Service reports that neither Federal law nor administrative regulation prohibits the printing of the physician's narcotic registration number on prescription blanks. However, the Narcotic Bureau prefers that physicians have their prescription blanks printed without including the narcotic registry number. According to the Bureau, if the physician follows the practice of writing in his registry number at the time narcotic prescriptions are issued, it will facilitate the easier detection of forged precriptions.

PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Index Medicus* published monthly by the National Library of Medicine, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text. References will not be published with the article, but will be available upon request to the Journal.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

When Malpractice Threatens
Should You Fight or Settle?

HERE'S A HELPFUL FORMULA FOR HANDLING A DELICATE SITUATION

LET'S face it—there is no guarantee against a malpractice suit. Sooner or later, you'll almost certainly be faced with a claim, justified or not. How you react may save your reputation, protect your pocketbook, and stave off a flood of nuisance suits.

Each case is different, but here are some fundamentals that every doctor should know:

1. Keep your eyes open

Watch your patient's emotional and psychological reactions. Be alert to dissatisfaction, grumbling, and uneasiness of the patient or his family. Keep an ear cocked for rumors from outside. Early recognition may give you time to repair strained relations.

2. Don't panic-just listen

Your real test will come when the complaint or accusation is made. There's a strong temptation to defend yourself, argue, alibi, explain, or even retaliate. If you remember nothing else, remember this: Don't do it. Just listen carefully and patiently and be thankful you're getting that much advance notice.

3. Speak with extreme caution

Anything you say may be held against you. Not long ago a patient threatened a Wisconsin physician with malpractice when her "sprained knee" turned into a long-term disability. Confronted in his office by the patient, the doctor did a quick recheck of the situation and replied, in effect, "You're right. If I'd taken a couple of follow-up x-rays three months ago, we would have caught it." This admission was "manna from heaven" to the patient. Whether or not the doctor's treatment had been good medical practice, his impromptu remark forfeited any defense he might have had. The case was settled out of court.

The case of the sprained knee is a good example of what lawyers call "the doctrine of *res ipsa loquitur*," that is, the thing speaks for itself. Technically, *res ipsa loquitur* is held to apply whenever one person is injured by an instrumentality entirely in the control of another person, the use of which does not ordinarily result in injury if the person in control exercises due care.

In the field of malpractice, the doctrine of *res ipsa loquitur* has been applied chiefly to cases which involve slipping instruments; sponges left in the tissues; burns from heating modalities; roentgen radiation injuries, generally limited to cases in which the roentgen ray is being used in diagnosis; infection through the use of an unsterilized needle or instrument; or injury to a portion of an anesthetized patient's body outside the field of treatment or operation.

Similarly, a single careless statement or admission might create liability for damages where no liability exists. What is more, an admission on the part of the defendant may free the plaintiff from the necessity of offering medical expert testimony to prove the alleged malpractice. The doctrine of *res ipsa loquitur* infers negligence on the part of the defendant. Its application forces the defendant to explain away the inference if he can.

4. Be quick to notify your insurance carrier

As soon as you suspect a malpractice suit in the making, notify your malpractice insurance carrier immediately and get private legal counsel. Don't wait. Any delay may be disastrous to the preparation of a defense. Adequate defense in the unjust malpractice case is a difficult task. No doubt poor defense has lost many a case. Physicians with little or no knowledge of the law are obviously out of place in attempting to defend themselves. Lawyers with little or no medical knowledge or experience in malpractice cases are not a good bet. In the face of a suit, you will be wise to find the best available expert advice.

5. Be slow to compromise

Don't be too quick to settle. Many doctors operate on the theory that a small settlement will be less expensive than the cost, publicity, loss of time, and mental and emotional strain involved in the defense.

Experience shows that unjust and absurd malpractice claims double and triple in areas where doctors are found to be a "soft touch." The increased number of malpractice claims and the higher insurance rates are a direct result of the "settle-it-quick" attitude on the part of many doctors. For your sake and that of your colleagues, you should make a determined opposition to any unjustified claims.

6. Collect your defenses

At the slightest possibility of a claim, begin to pull together your records, reports, and other evidence which might be required for your defense. At this point, every shred of recorded evidence becomes mighty important. But in no case should you alter your existing records in any way.

7. Settle a meritorious claim out of court

The doctor who is actually guilty of malpractice is not likely and probably should not be allowed to go free of penalty. Let your conscience, not alone your pride, be your guide. Meritorious claims should be settled out of court—preferably before a suit has been filed. But never settle without having competent legal advice.

POISON INFORMATION CENTERS

MADISON	•	**Phone AL 6–6811**

Call University Hospitals, ALpine 6–6811, and ask for "Poison Center" for information concerning any substance suspected of being poisonous.

MILWAUKEE	•	**Phone DI 4–7100**

The Poison Information Center in Milwaukee was established in 1956 through the efforts of The Medical Society of Milwaukee County Subcommittee on Accident Prevention. It is located in Milwaukee Children's Hospital.

EAU CLAIRE	•	**Phone TE 2–6611**

The Poison Information Center for physicians in the Eau Claire area is located at Luther Hospital.

GREEN BAY	•	**Phone HE 5–5311**

For physicians in the Green Bay area, the Poison Information Center is located at Bellin Memorial Hospital.

KENOSHA	•	**Phone OL 4–5311**

The Poison Information Center for physicians in the Kenosha area is located at Kenosha Hospital.

The Poison Information Centers maintain complete information on poisons by commercial name, ingredients, relative toxicity and treatment procedures. Their files are kept current through periodic releases received from the Clearing House for Poison Control Centers in Washington, D.C.

The Doctor's Role in Adoptions

Here is what the physician can do to keep sentiment from overruling caution in adoptions

WITH over 2,000 illegitimate children born in Wisconsin each year, it is only a matter of time before the physician is approached by an unwed mother or a married couple seeking a child.

No warning can be too emphatic: Avoid all entanglement with the emotional and legal webs that surround child placement.

The physician's role in adoptions is clear: Suggest immediately that the parties involved consult with either a licensed child welfare agency or an authorized public agency.

Wisconsin laws, long outstanding for the protection of adoptive children, were further strengthened when the legislature adopted a new Children's Code in 1955. Sec. 48.63 (2), Wis. Stats., 1959, prohibits all nonauthorized persons, *including physicians* and attorneys, from any act as intermediaries in finding children for adoption or making placements. In fact, these statutes specify that: "No parent or guardian, except a licensed child welfare agency or public agency authorized to place children for adoption, may place a child in a foster home for adoption without obtaining the written approval of the county court . . ."

Stiff penalties back up the law: Fines up to $500 or imprisonment up to one year in the county jail, or both. See Sec. 48.76, Wis. Stats., 1959.

Here is what the physician can and cannot do:

The Physician

SHOULD ALWAYS urge the unwed mother, prospective parents, or others to consult with either a licensed child welfare agency or an authorized public agency. If questions arise, the physician should consult the Division for Children and Youth, State Office Bldg., Room 385, Madison 2, Wisconsin, the state administrative agency charged with such matters.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 2.

Catholic Social Welfare Bureau, 207 East Michigan Ave., Milwaukee 2.

Catholic Welfare Agency, 1209 Hughitt, Superior.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse.

Catholic Welfare Bureau, 25 S. Hancock, Madison 3.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 13.

Lutheran Welfare Society of Wisconsin, 3126 West Highland Boulevard, Milwaukee 8.

Jewish Family and Children's Service, 2218 North Third Street, Milwaukee 12.

PUBLIC AGENCIES:

*Wisconsin Division for Children and Youth, Room 385, State Office Bldg., Madison 2.

*Milwaukee County Department of Public Welfare, Child Welfare Division, County Court House, Milwaukee 3.

LICENSED MATERNITY HOMES:

*Martha Washington Home, 6306 Cedar Street, Wauwatosa.

Misericordia Hospital (Catholic), 1225 North 22nd Street, Milwaukee 3.

St. Francis Hospital (Catholic), 1020 Market Street, La Crosse (temporarily closed due to a building program).

St. Mary's Home (Catholic), 435 South Webster Avenue, Green Bay.

Fees for care in licensed maternity homes vary from $130 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Several institutions provide employment opportunities to cover part of the cost of service rendered. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

MUST NOT suggest to any unmarried mother, other natural parent, or legal guardian any particular foster parents for a child he believes available for adoption.

MUST NOT offer to find foster parents for such a child.

MUST NOT offer to find a child for adoption by prospective foster parents.

MUST NOT place a child with foster parents on a trial or any other basis.

MUST NOT act in any other way as negotiator or intermediary in such matters.

MUST NOT in any other way risk possible violation of the clear terms of the statute.

Professional reputation and ethical standing, as well as a police record, are at stake in the physician's dealings with the unwed mother or prospective parents. Thus, it is absolutely essential that he avoid any conduct which might cause the public to view him as associated with a "black market in babies."

It may help the physician to know that the declared policy of the State of Wisconsin gives paramount concern to the welfare of the child in any adoption procedure. The parents, guardian, and the public interest have secondary consideration. Thus, the Children's Code, by insisting on referral of adoption cases to authorized agencies, offers the physician practical and highly professional recourse in what might otherwise be a dangerous sentimental action.

Sec. 48.78, Wis. Stats., provides that no records kept or information received relative to individuals, their care or legal custody shall be open to inspection or their contents disclosed except by order of the county court. Even the exchange of information between authorized agencies, or social welfare organizations is required to be on a confidential basis.

REFERENCES

Wis. Stats., 1959, Sections 48.01 (3), 48.60, 48.62 and 48.65.

WHAT ARE YOUR RIGHTS IN EMERGENCIES?

Question: Suppose a physician in private practice serves as advisor to his local police department. The department calls him, either to the police station or to a private home, where a belligerent alcoholic is creating a disturbance. The physician gives a hypodermic injection to calm him, without the alcoholic's consent, and with or without the nearby relatives' consent. The alcoholic is believed to be endangering himself or those in his environment. Is the physician within his legal rights as a doctor called by the police?

Suppose a similar sequence occurs with a mentally ill patient. The police are following the physician's orders in these circumstances. To protect the patient and others from the violence of the patient, the physician orders restraints applied. Is he within his legal rights as a doctor called in by the police? Assume that no relative is immediately available to take responsibility of the patient.

Answer: Generally, a physician has no authority to administer a hypodermic injection or any other treatment to a patient without the consent of the patient or someone authorized to act on his behalf. If the patient is mentally incapable of speaking for himself because of intoxication, injury, illness, or insanity, consent must be obtained from someone legally authorized to act on behalf of the patient.

An exception is permitted in the case of an emergency, where the patient's life is endangered. Under these circumstances, the law will presume the patient's consent on the theory that, if the patient were rational and able to make his own decision, he would consent to treatment.

A physician going into a private home has no authority to treat the patient without the consent of the patient, or someone authorized to act on his behalf, unless a bona-fide emergency exists in which the patient's life is endangered. Except with regard to persons committed to state institutions, and other situations where specific statutory authority is granted, the police have no authority to authorize a physician to drug a patient against his will solely because he is creating a disturbance or endangering others. The police have power to restrain such an individual by force, if necessary, although force does not include the use of drugs. However, where a patient becomes so violent that it is necessary to restrain him with drugs, the situation is usually one where treatment can be justified because of a bona-fide emergency. Reference: "The Physician's Legal Rights in Emergencies," J.A.M.A. (Queries and Minor Notes Section) 161:1518 (Aug. 11) 1956.

Problems of the Physician's Widow

DURING 1961 death came to 51 members of the State Medical Society. In every appropriate case, the Society wrote the physician's widow seeking to provide assistance during a trying period. The Society, believing the adage that "an ounce of prevention is worth a pound of cure," suggests that every member give thoughtful consideration to the problems which might face any physician's widow.

Several problems are almost certain to confront the widow who in the days immediately following a physician's death is suddenly pressed into the position of managing the estate and drawing together the loose ends of what was once an active practice. Careful preparation for this eventuality can not only protect the welfare of the family, but ease their burdens at a trying time.

With the death of a physician the widow will be faced with many decisions regarding the collection of outstanding accounts and the settlement of many business matters relating to the physician's practice. Thus, it is extremely important that she proceed slowly acting ordinarily only upon the advice of an attorney. It is obvious that the selection of this attorney and acquaintance between the attorney and the physician's wife is a prerequisite to an easier relationship in event of the physician's death.

Case records of patients and malpractice insurance policies of the physician should not be destroyed for at least three years. Liability for malpractice does not cease upon the death of a physician, and such actions may be started against a physician's estate by filing within a period of three years from his death. The physician's records and liability insurance policies may be the widow's only defense. Every precaution should be taken to insure that these records are kept intact subject to immediate call for at least three years.

Of course, one can expect that the deceased physician's patients will seek care elsewhere. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In this event it is wise to insist upon a personal request from the physician and to transmit the record with a cover letter confirming the transfer.

Former patients may seek a continuation of medication prescribed by the deceased physician. This should be carefully avoided because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The deceased physician's narcotic license must be surrendered as soon as possible along with any supply of narcotic drugs. These should be sent to the U. S. Treasury Department, Narcotics Division, 628 East Michigan, Milwaukee, Wisconsin.

In any event, the State Medical Society Office is always available for consultation. Though there may be many who urge speedy settlement of all aspects of a deceased physician's practice, the wisest counsel is found in proceeding slowly and with competent legal advice.

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

1. He is recommended for a temporary license by any physician licensed in Wisconsin.
2. He is under medical care.
3. While under medication he is free from seizures.
4. His driving is not otherwise a hazard to public safety.
5. His physician recertifies each six months that he is free from seizures.

The physician makes his certification on a combined questionnaire and recommendation form provided by the Motor Vehicle Department. The physician making such a recommendation must be the physician who is rendering treatment to the epileptic patient. The issuance of a temporary license is discretionary with the Motor Vehicle Department. A denial may be reviewed, however, by a special board of five members. Four of these members are designated by the president of the State Board of Health.**

Reference: Section 343.09, Wisconsin Statutes, 1959.

** The fifth member is the Commissioner of the Motor Vehicle Department, and he and any two of the other members constitute a quorum.

A Word of Caution Before Discarding Case Records and X-Rays

PAPER work has many physicians on the verge of hysteria. There's more of it. It costs more to produce. It takes more office personnel. It takes more time. And what's more, the records of it live to haunt you.

Here's what's happening around Wisconsin:

★ A clinic in operation for 20 years has a large room filled to overflowing with bulky case records. Expansion of storage is expensive. But conversion to newer, less space-consuming records would cost over $2,000.

★ Another two-man clinic started three years ago is grumbling over bulky, inconvenient records and the accumulation of paper and is already pushing into valuable examining and laboratory room space.

★ One physician was literally forced out of house and home when his wife objected to records from the home-attached office spilling over into the living room.

Can a systematic destruction program solve this problem? How long should you keep your professional case records and x-rays?

With a couple of limitations, the professional records of physicians are generally considered the property of the physician who makes them. Of course, he must be able to assure the patients that the records are being kept in confidence; and ethical considerations require that he make them available to a succeeding physician upon the request of the patient.

Otherwise, you have a clear property right to your professional records and x-rays. Thus, you have the legal right to destroy them, except when prohibited by statute.

But before you toss the whole "kit and caboodle" into a bonfire, here are a half dozen good rules to remember:

1. Keep narcotic and other prescriptions at least two years. If you don't, you face severe penalty—even revocation of your narcotic license. The State Board of Health prescribes the records you should keep on narcotics. Follow its advice, and you will meet the requirements of both the Wisconsin and federal statutes.
2. Retain all other patient records as long as they have any conceivable value, either to the physician or to the patient—and in no event for less than six years. This, you say, could be forever. That may or may not be. Here are some examples:

★ Premature destruction of professional records and x-rays could obviously be a disservice to the patient and result in great harm in many situations.

★ A patient who has not used your services for many years might return specifically because you had once cared for him. Even if a patient seems to be leaving the reasonable vicinity of your service, you may be called upon to provide a succeeding physician with his records.

★ Your records should be retained for that period of time during which the record of treatment and diagnosis may be needed by the patient in the prosecution or defense of

WHAT WOULD YOU DO?

SITUATION: Mrs. John Jones was diagnosed as cancer, malignant. Prognosis: Poor. She left Wisconsin to live with relatives in Oregon. Six months later she wrote her previous physician, Dr. John Doe, asking that he send her complete medical record to her new doctor in Portland. Doctor Doe protested, saying her voluminous record of care and treatment for the previous five years, including x-rays, would be costly to reproduce.

COMMENT: Doctor Doe has an obligation to make his records available to a succeeding physician at Mrs. Jones' request. The force behind this is mainly ethical, but the failure to provide adequate records with reasonable promptness for the use of the succeeding physician may jeopardize Mrs. Jones' health and thus open a possibility of a malpractice claim where none existed before. On the other hand, Doctor Doe is not required to send his only copies of these records and might reasonably request Mrs. Jones to pay the cost of reproduction for the necessary copies. If there is a question of malpractice involved, consult your attorney, insurance company, or the State Society office.

a legal action or in the establishment of some legal right. Records are of particular importance to the patient in establishing a service-connected disability claim against the Veterans Administration, in determining the mental capacity in a will contest, in evaluating personal injury in an automobile accident, and in determining the extent of disability resulting from an industrial accident in a claim under the Workmen's Compensation Act.

★ Records are vital for defense in malpractice claims against the attending physician and the hospital, if it is involved. Wisconsin statutes require that one alleging a malpractice must assert that claim by institution of legal action within three years of the occurrence of the alleged event. This applies even to those who may be incapacitated by reason of infancy or insanity. Even when no suit has been filed within three years, the patient may still question the value or quality of the professional service as a defense to an action by the physician to collect fees. A collection suit will not then revive the patient's right to damages, but the lapse of that right will not keep him from arguing that the services were so far below standard as to be noncompensable. Such a collection action must be commenced within six years. Thus, if you think it may be necessary to resort to legal action in the collection of your fee, it would be smart to keep your professional records for at least that six-year period.

3. Keep all pertinent records indefinitely as long as there is a known or threatened legal complication such as a malpractice or collection suit.
4. When a suit is actually brought against you by a patient (or someone acting for him), you must preserve all patient records, including x-rays, laboratory reports, and correspondence, until your attorney advises that in his judgment the time is past within which other litigation that might grow out of the first suit could be brought. This may be some time after the litigation has been concluded.
5. If you should bring a suit against a patient, the same time periods must be carefully observed, leaving the final determination to the judgment of an attorney.
6. Records should be preserved even longer than usual if the case is affected by mental incapacity, infancy, or imprisonment of the patient. Rely on your attorney's advice.

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Consent for a physician to conduct a post mortem examination is considered sufficient when it is given by the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Section 155.05, Wisconsin Statutes, 1959.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Some birth certificates filed with the State Board of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Committee on Maternal and Child Welfare believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Board of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a possible fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes, 1959.

Locum Tenens

For a variety of reasons a physician may have occasion to leave his practice for an extended period of time. The choice of the interim custodian of his practice and the arrangement under which he carries it on are then of very real importance.

IN THOSE cases where a locum tenens is secured, the State Medical Society urges that the arrangements be confirmed by a written contract, drawn with the assistance of a local attorney. In arriving at the terms of such an agreement members should consider these fundamental points:

Licensure

The locum tenens must be licensed in Wisconsin as one entitled to practice medicine and surgery. Membership in a local and State Society is further assurance of his ethical standing and abilities.

Staff Privileges

Association on the hospital medical staff, where necessary, should be arranged. The locum tenens should be apprised of the conditions necessary to a continuation of this association, and his compliance with them should be a continuing condition of the contract.

Malpractice Liability

Malpractice insurance should be maintained by both parties under all circumstances.

Partners, Independent Contractor, or Employe

One of the most important matters for decision is that of determining the relationship under which the locum tenens is to assume management of the office. Your own attorney can best describe the practical aspects of this problem. It is sufficient to say that there is a real distinction between these with respect to liability of the principal party for the acts of the locum tenens, and with respect to his power to bind or otherwise obligate his absent confrere. In deciding this relationship, consideration must necessarily be given to the extent the locum tenens is to control the practice. For example, may he move the office acting upon his best judgment alone? Or may he make such purchases to the office account as his judgment dictates? Are the costs of operation to be a joint burden, and in any event, what are they?

Financial Arrangements

Whether the locum tenens is reimbursed on a salary or drawing basis, arrangements must be made with respect to handling withdrawals, the financial records to be kept, collection policy and obligations of locum tenens with respect to accounts receivable of the physician.

Locum Tenens to Give Entire Time

As an essential provision of the contract, provisions should be made with reference to the amount of time that the locum tenens is to devote to the practice. Is he to give his entire time and not to engage in any business which would detract from his abilities to serve the community professionally?

Costs of Operation

If the salary or drawing arrangement with the locum tenens is to be based on the percentage of net income after payment of operating costs, items of costs should be specified so nearly as can be determined. If the physician should own his own office, it is only proper that a rent basis for use of the office be established, and such items as light, heat, wages, insurance, supplies and equipment and the like should all be taken into consideration.

The physicians must likewise determine their policy with reference to accounting for collections for services rendered prior to execution of the agreement by the departing physician. Are these to be considered income under the contract or are they excluded?

Restriction on Practice After Termination of Agreement

Wisconsin recognizes the validity of clauses restricting practice after termination of a contract of employment. Your attorney may refer to the Wisconsin Statutes (1959) Section 103.465 and the case of *Lakeside Oil Company, Inc. v. Slutsky* (1959) 8 Wis. 2d 157 and the cases cited therein. The rule in Wisconsin requires that a restrictive covenant not to compete after a term of employment should be reasonably necessary for the protection of the legitimate interests of the employer and at the same time should not be oppressive and harsh on the employe or injurious to the interests of the general public. An unreasonable restraint is void and unenforceable even to those parts of the restraint which would constitute a reasonable restraint.

Therefore, great care should be taken when drafting such a clause so as to make the restraint fit within the Wisconsin rule.

Termination

A provision for termination of the contract should be made. At the option of the party a definite date may be selected or termination can depend upon the time when the absent associate returns, or may be of indefinite duration, and terminable upon sixty or more days' notice. In any event it should be stated that failure on the part of the locum tenens to carry out in good faith the provisions of the contract should be cause for termination without notice.

Miscellaneous Matters

Other matters which a physician may desire to pass upon may include questions concerning the handling of certain business and personal matters of the absentee member, as well as the form of stationery, billing head, prescriptions, liquidation after termination of the agreement of accounts receivable arising during the operation by the locum tenens of the practice, care and replacement of medical instruments and the like.

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. **Medical Care of Migrant Agricultural Workers**
   A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **School Health Examinations**
    A guide for physicians and school authorities in establishing a program of school health examinations.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**
    A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

NOTE: The January Blue Book issue of the Wisconsin Medical Journal is a handy reference on medico-legal subjects. Keep this issue and refer to it often.

A Record of Value to You and Your Patients

The Study Committee of the Maternal Mortality Survey of the State Medical Society has devised for pregnant patients a record form which is highly recommended for use in the physician's office and also as a record kept in the hospital during the last month of pregnancy with any notations as to special care which might be required if the patient is brought to the hospital and delivery is precipitous, before the attending physician can arrive.

If you are not acquainted with the form, it is suggested that you write for a sample sheet; and if found suitable for your practice, that you order a supply and use the forms as recommended. It is felt by the Study Committee that use of the forms may help to meet some emergency problems and avoid complications which may result in patient demise.

T. A. Leonard, M.D.
Chairman, Study Committee
Maternal Mortality Survey

Prenatal Facts

SUGGESTED PROCEDURE } **File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.**

Name _____ Address _____ igion _____
Expected date of confinement _____ -- Para_____
Number of abortions_____ miscarriage_____ del_____
multiple birth
Nature _____
Weig _____
Speci _____
_____
Chest _____
Evaluati _____
Wasserma _____
Coombs te _____
Date of visi _____
Weight _____
Heart _____

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
Division on Maternal and Child Welfare
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1962, you must pay the final installment of the estimated federal tax on your 1961 income. This may necessitate an amended declaration by that date if you find that you underestimated 1961 income. A final income tax return for 1961, filed before January 31, 1962, will be treated as the equivalent of an amended declaration as of January 15. Penalties are assessed for certain underestimating of taxes. These penalties and their legal avoidance are discussed in Section 5 below.
2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1961 on Form W–3.
   (2) Furnish a statement to employees on Form W–2 showing wages paid and amount of tax withheld during the calendar year 1961.
   (3) File fourth quarterly return for 1961 of income and social security tax withheld on wages paid employees on Form 941 if:
      (a) The entire tax was not paid by timely depositary receipts for all three months of the preceding quarter; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1961.
   (4) Pay income and social security taxes withheld on 1961 wages of employees if:
      (a) More than $100 was withheld in December, 1961, and not paid to government depositary earlier in January, 1962; or
      (b) Less than $100 was withheld in each of the months of October, November, and December, 1961.
3. Miscellaneous:
   (1) If the total of income and social security tax withheld on employees' wages exceeds $100 a month in each of the three months of the preceding calendar quarter, and payments were made to a government depositary previous to the fifteenth of the next month, the quarterly return on Form 941 should be filed on or before the tenth of February, May, August, and November, as the case may be.
   (2) If instructions contained in paragraphs (3) and (4) of Section 2 preceding are applicable to your situation, make similar quarterly payments and returns on April 30, July 31, and October 31, 1962, for the respective preceding calendar quarters.
   (3) If income and social security taxes withheld on employees' wages exceed $100 in either the first or second months of each calendar quarter, the amount thereof should be paid to a government depositary by the fifteenth of the following month. The amount of such withheld taxes for the last month of each quarter may either be paid to a government depositary by the fifteenth of the month immediately following or may accompany the quarterly return if the latter is filed by the end of the month following such calendar quarter.
4. File your Wisconsin and federal partnership and personal income tax returns as early in 1962 as possible, but no later than April 15. State returns should be filed with the assessor of incomes in the district in which you live, Federal returns with the Director of Internal Revenue, Milwaukee.
5. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1961 income must be shown on a federal declaration form which has to be filed, together with the estimated tax due, by April 15, 1962. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1962. As to the final payment or amendment of declaration due in January, 1963, follow the alternative procedure described in Section 1 above.

Excluding cases of willful understatement, interest penalties are provided for underestimating and thus underpaying taxes on declaration of estimated income, to the extent that each quarterly installment is under 70 per cent of one-fourth of the tax due for the year, as shown on the filed return. A penalty of 6 per cent computed on the amount of the underpayment from the due date of a particular installment is added to the tax. The penalty can be legally avoided in either of two ways. The first is to base the estimated tax upon the previous year's income at 1962 tax rates and exemptions in force at the time a particular installment is being paid, or to base quarterly payments on the previous year's tax, whichever is the lesser. The second is to follow the so-called "90 per cent rule." This is a rather complicated formula, and each physician who cares to follow it should consult his attorney or tax accountant.

ANNUAL REGISTRATION IN WISCONSIN

1. Register with the Secretary of the Wisconsin State Board of Medical Examiners, Room 1140, State Office Building, 1 West Wilson Street, Madison 3, in the month of January. This registration will be on a form furnished by the Board of Medical Examiners.

ANNUAL NARCOTICS REGISTRATION

1. Register with the Bureau of Internal Revenue, Milwaukee, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1962. You are subject to penalties for overlooking either the registration or the tax.

CHANGE OF RESIDENCE

1. Notify the Director of Internal Revenue, Milwaukee, Wisconsin, to insure the legality of your narcotics license. Penalties are imposed for failure to do this.

REMEMBER TO:

1. Make prompt report to the State Board of Health, State Office Building, 1 West Wilson Street, Madison 3, of cancer cases, communicable diseases and others.
2. File with the city health officer or county register of deeds a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.30 (1), Wis. Statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician, or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), Wis. Statutes.
5. Report *immediately* the following deaths, as required by Section 966.20, Wis. Statutes, to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal, or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there is no physician in attendance.
   h. When a physician refuses to sign the death certificate.

FEDERAL AND WISCONSIN UNEMPLOYMENT COMPENSATION LIABILITY

See in this connection the text of the box on page 21 of this issue.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, by-laws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, by-laws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by the provisions of s. 200.26 and by no other law relating to insurance unless such law is referred to in s. 200.26 and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the perquisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

* As last amended by the 1960 House of Delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

The term "full-paid members," as used in this section, includes regular members of the Society,

life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.

b. On Resolutions.

c. On Reports of Officers.

d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its mem-

bers as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and

shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Commission on Scientific Medicine
A Commission on Public Relations and Communications
A Commission on Public Policy.
A Committee on Grievances.
A Commission on Hospital Relations and Medical Education.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Cancer.

Unless otherwise provided in these Bylaws, each of these committees shall consist of five members, each of whom shall serve for a term of five years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each.

SEC. 2. The Commission on Scientific Medicine shall consist of five *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the Wisconsin Medical Journal. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Commission on Public Relations and Communications shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Public Relations and Communications shall study, make recommendations, and implement approved activities to improve the distribution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven members, and the president, the president-elect and secretary. The commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 5. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice. The committee shall possess similar responsibilities where request is made to investigate complaints bearing upon a member's alleged violation of any provision of the Medical Practice Act.

The committee shall consist of nine members and the terms of one-third of its members shall expire each year, with each member appointed for a term of three years.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president,

the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The Wisconsin Medical Journal shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted on payment of $10 annual dues.

SEC. 5. *Educational Memberships:* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine. shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 7. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a bona-fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may pro-

vide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked or suspended shall be dropped from membership automatically as of the date of revocation or suspension. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service.

CHAPTER XII

SECTION ON MEDICAL HISTORY

Membership in this Section shall be composed of those interested in preserving medical history in Wisconsin. The Section shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Section and shall not exceed $10 per year. The Section is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Section shall be segregated, and ex-

penditures from them shall be made under direction and supervision of the Section, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Section, and displays may be developed by the Section for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII
SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

PHYSICIANS

A new classified advertising section starts with this issue of the Journal. Now you can advertise personal belongings, real estate, equipment, etc. which might be of interest to your colleagues. Have you a boat to sell? Do you want to dispose of a lake cottage? Are you looking for a used piano for the recreation room? Perhaps another physician is interested. Find out by advertising in the classified ad section of the Journal. For particulars turn to page 60 of the advertising section.

A NEW WAY TO COMMUNICATE WITH YOUR COLLEAGUES

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, and alleged father to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Wisconsin Statutes, 1959, Sections 325.23 and 52.36.

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

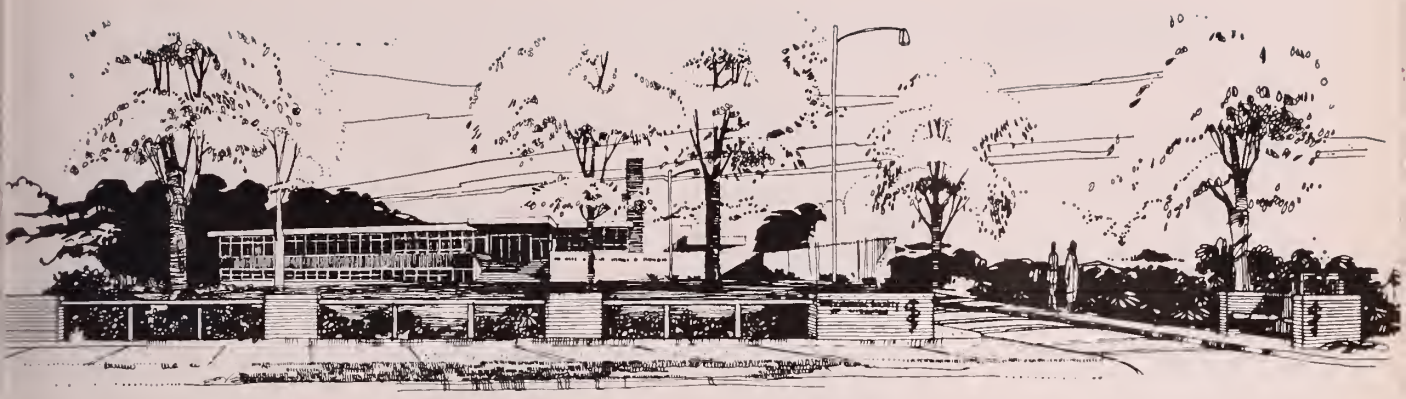
Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957



STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON 5, WISCONSIN

The "Hame" of the State Medicol Society on the south shore of Loke Monona houses the Wisconsin Medicol Journal, the Society's Blue Shield plon, general administrative offices, dining room, and Council room. Nearly 200 committee and other meetings ore held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Medical Student Loans

Grievance Services

Museum of Medical Progress

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

WPS Protection

Open Panel Program
under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medico–Legal Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

Adams:
Weihe, A. R.

Adell:
Bemis, I. M.
Naylen, F. J.

Albany:
Bongiorno, F. J.

Algoma:
Hopkins, R. G.
March, J. F.
Pudleiner, H. G.
Stiehl, C. W.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Whitlark, F. L.

Amherst:
Osicka, S. R.

Antigo:
Beattie, B. W.
Cromer, R. W.
Curran, W. P.
Dorzeski, E. F.
Garbisch, F. H.
Garritty, J. E.
Kaschel, P. E.
Lambert, J. W.
McKenna, E. A.
Moore, G. E.
Seilin, Josef

Appleton:
Adrians, W. A.
Anderson, J. G.
Benton, J. L.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cooper, H. G.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Engstrom, D. P.
Erchul, J. W.
Frawley, W. J.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Green, C. J.
Gross, H. T.
Hale, William H.
Hamel, H. H.
Harrington, Wm. J.
Hauch, F. M.
Haza, B. J.
Hegner, G. T.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Konz, S. A.
Krueger, E. N.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
MacLaren, J. B.
Marshall, F. S.
Marshall, V. F.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, E. F.
Miller, E. J.
Neidhold, C. D.
Nichols, G. P.
Park, R. K.
Petersen, G. J.
Plouff, L. T.
Raney, E. H.
Rankin, F. J.
Russell, J. H.
Savage, G. W.
Siegrist, K. J.
Simenson, R. S.
Swanton, M. E.
Taylor, A. C.
Veum, J. S.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.

Arcadia:
Comstock, Elizabeth

Argyle:
Hunter, R. E.

Arpin:
Ryan, C. J.

Ashland:
Bargholtz, W. E.
Grand, C. A.
Grigsby, R. O.
Jauquet, J. M.
Kreher, J. E.
Larson, H. H.
Merrill, W. G.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Smiles, W. J.
Stanley, R. A.
Tucker, W. J.
Weeks, F. D.

Athens:
Martens, T. J.

Augusta:
Moland, O. G.
Thieda, E. S.

Baldwin:
Olson, C. A.
Sargeant, G. M.
Torkelson, L. B.

Balsam Lake:
Burdette, Stella I.

Bangor:
Ruppenthal, K. P.

Baraboo:
Edwards, A. C.
Hannan, K. D. L.
Huth, M. F.
Pearson, C. R.
Pischke, E. F.
Siebert, J. T.

Barron:
Macmillan, D. G.
Saydjari, M. S.
Strang, C. J.
Whaley, R. C.

Bayfield:
Moody, L. W.

Bear Creek:
Morneau, L. F.

Beaver Dam:
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Corso, Xavier
Davis, T. C., Jr.
Drescher, G. G.
Erickson, N. W.
Funcke, Wm. E.
Kores, A. B.
Link, D. L.
Qualls, C. L.
Richards, W. G.
Roberts, R. R.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Allen, W. J.
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Clark, D. M.
Cochrane, W. L.
Crockett, W. W.
Fitzgerald, W. M.
Flarity, T. H.
Freeman, W. S.
Glesne, O. G.
Gunderson, R. H.
Johnson, F. K.
Jones, E. T.
Kasten, H. E.
Kishpaugh, H. W.
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Matthews, G. C.
Mauermann, W. J.
Nora, J. J.
Ottow, A. F.
Pollard, W. H., Jr.
Pruett, W. A.
Raube, H A.
Sanderson, R. J.
Scholten, W. A., Jr.
Springberg, J. C.
Thayer, R. A.
Thomson, G. H.
Tuftee, A. O.
Twyman, A. H.
Woodington, G. F.

Berlin:
Koch, H. C.
Koch, J. C.
Seward, L. J.
Sievers, D. J.
Stone, G. C.
Taugher, V. J.

Big Bend:
Raschbacher, J. L.

Birnamwood:
Damp, O. E.

Black Creek:
Querol, J. T.

Black River Falls:
Holder, R. L.
Krohn, J. I.
Krohn, Robert
Marks, J. R.
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Blanchardville:
Unterholzner, L. J.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Hudek, D. F.
Murphy, P. W.

Bloomington:
Edwards, P. K.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Boyd:
Sallis, D. A.

Brandon:
Adams, H. G.
Lautenbach, E. T.

Brodhead:
Hein, W. E.
Stuessy, M. W.

Brown Deer:
Kohne, B. D.

Brookfield:
Benoit, M. P.
Davis, J. B.
Hoffman, J. R.
Hyslop, V. B.
Lubitz, J. M.
Pavlic, R. S.
Roth, D. A.
Stoklos, Michael
Teresi, J. L.
Werts, K. G.

Brownsville:
Friedrich, L. E.
Raymond, R. G.
Ries, M. F.

Bruce:
Whalen, M. L.

Burlington:
Baker, D. J.
Erickson, L. W.
Granzeau, H. W.
Mastalir, L. O.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Butler:
Schoeneman, R. H.

Butternut:
Boldt, R. E.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

* As of December 15, 1961.

Cambria:
Brown, J. G.

Cambridge:
Amundson, K. K.
Nemec, George, Jr.

Campbellsport:
Graves, R. H.
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cashton:
Mauel, N. M.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Roller, Mac C.

Chilton:
Humke, E. W.
Humke, K. R.
Knauf, J. W.
Knauf, R. E.

Chippewa Falls:
Brown, F. J.
Graber, R. E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Janc, W. F.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, F. B.
Sazama, J. J.
Shonat, G. C.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Minter, D. L.
Thomas, W. O.

Clintonville:
Arnold, W. G.
Auld, Irving
Bate, L. C.
Caskey, H. S.
Larson, Owen E.
Topp, C. A.

Cochrane:
Meill, E. A.

Colby:
Hansen, R. L.
Koch, James W
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Felland, O. M.

Columbus:
Cheli, C. F.
Poser, J. F.
Poser, R. F.
Shearer, C. E

Cornell:
Hendrickson, R. L.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Cross Plains:
Lappley, W. F.
McEnroe, J. E.

Cuba City:
King, C. S.
Stone, M. M.
Taylor, H. W., Jr.
Terry, R. E.

Cudahy:
Abrams, J. E.
Ackerman, D. S.
Chelius, C. J.
Fine, J. M.
Homsey, J. J.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Malone, J. A.
Marcich, Z. P.
Pizer, J. A.
Rosenbaum, M. K.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.
Lund, S. O.
Thompson, R. C.

Darien:
Truex, G. O., Jr.

Darlington:
McConnell, E. D.
McGreane, N. A.
Oertley, Robert E.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.
Wade, Chester

Delavan:
Crowe, N. F.
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Roesler, M. J.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.
Michna, C. T.

De Pere:
Elders, W. F.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

De Soto:
Bolstad, H. A.

Dodgeville:
Buckner, H. M.
Downs, D. R.
Hamilton, W. P.
Morton, H. H.
Rasmussen, N. G.

Durand:
Blose, Irvin L.
Bryant, R. J.
Springer, J. P.

Eagle:
Nothum, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Kohn, Louis

Eau Claire:
Aitken, H. M.
Anderson, F. G.
Aronson, Willard
Bates, P. J.
Beebe, G. W.
Bjurstrom, R. O.
Blom, Julius
Brousseau, E. A.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Carlson, S. D.
Derge, H. F.
Dibble, J. B.
Falstad, C. H.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Griffith, D. R.
Haag, A. F.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kennedy, R. L.
Kilkenny, T. E.
Kinsman, F. C.
Klein, A. J.
Lindquist, M. F.
Lorenz, A. A.
Lotz, R. M.
Lowe, J. W.
Manz, W. R.
Martins, J. K.
Mautz, W. T.
McAfee, G. D.
Midelfart, Peter A. H.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Paulson, W. O.
Richards, R. R.
Russell, S. B.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Strand, R. C.
Thimke, H. E.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.
Zlegler, J. E. B.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Shcarer, T. M.
Sumner, W. C.

Eleho:
Dailey, D. W.
Dailey, P. J.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Rawlins, J. A.
Rogers, R. J.
Sorenson, E. D.
Stuessy, M. F.

Elm Grove:
Blake, W. J.
Denio, M. J., Jr.
Erwin, C. P.
Erwin, C. R.
Grade, J. O.
McCormick, G. E.
Myers, S. C.
Redlin, R. R.
Settimi, A. L.
Wisniewski, J. H.
Whitaker, P. J.
Zurheide, H. J.
Zurheide, H. O.

Elmwood:
Springer, F. A.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.
Sorkin, S. S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Bailey, M. A.
Howell, E. C.
Shields, C. H., Jr.

Fond du Lac:
Becker, N. O.
Bissegger, Arnold
Borsack, K. K.
Cerny, F. J.
Charles, J. E.
Fieber, W. W.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Huebner, J. S.
Hutter, A. M.
Keenan, L. J.
Kendell, W. G.
Kief, H. J.
Koll, J. H.
Leonard, C. W.
Liewen, B. E.
Mauthe, Howard
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meusel, H. H.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peterson, C. R.
Schroeder, R. W.
Sharpe, H. R.
Sharpe, H. R., Jr.
Sharpe, J. J.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Swan, J. C.
Theisen, S. A.
Twohig, D. J.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Forestville:
Hirschboeck, J. G.

Ft. Atkinson:
Aufderhaar, H. W.
Gruesen, F. A.
Gueldner, L. H.

Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Mallow, H. G. E.
Maloney, C. G.
Notbohm, D. R.
Russell, J. C. H.
Venning, J. R.
Voytek, J. J.

Fox Point:
Martin, D. H.
Peters, L. M.
Sibberman, Jack
Thompson, L. H.

Franksville:
Harris, W. C.

Frederic:
Andrews, W. C.
Fischer, W. A.
Moore, R. M.

Fredonia:
Wallestad, P. W.

Fremont:
Gloss, A. J.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Gillett:
Daley, E. F.
Klutzow, F. W.

Glendale:
Brand, W. D.
Brazy, R. R.

Glenwood City:
Limberg, A. W.
Limberg, P. W.
McCusker, C. F.

Grafton:
Pelant, K. F.
Seidl, J. A.

Grantsburg:
Cutshall, R. A.
Hartzell, R. L.

Green Bay:
Angus, D. C.
Austin, S. D.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Boersma, J. J.
Bolles, C. S.
Brusky, A. H.
Brusky, E. S.
Brusky, S. F.
Burdon, T. S.
Christensen, P. D.
Clark, E. V., Jr.
Cook, F. D.
Cowles, R. L.
Crawford, C. W.
Danaher, H. H.
Denys, G. F.
Denys, K. J.
Dettmann, J. E.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Goelz, J. R.
Grace, J. B.
Griggs, S. L.
Grossman, M. A.
Guthrie, J. M., Jr.
Hagerty, W. T.
Haines, A. W.
Halloin, J. E.
Hammes, D. A.
Hart, L. E.
Heitzman, H. H.
Hitch, O. M.
Hoegemeier, H. W.
Icks, K. R.
Jensen, R. E.
Johnston, R. E.
Kalina, B. F.
Kaufman, J. E.
Killeen, E. R.
Killins, J. A.
Killins, W. A.
Kispert, R. W.
Koenig, Harry
Kuehl, F. O.
Kuhs, M. L.
Kulkoski, Bernard
Le Mieux, G. E.
LeTellier, M. S.
Levitas, I. E.
Lynn, T. E.
Markey, J. P.
MacMullen, Wallace, II
McCarey, Arthur J.
McCormick, R. A.
McGuire, G. E.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Milson, B. I.
Milson, Louis
Mokrohisky, J. F.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. George, Jr.
Nellen, J. W.
Neu, V. F.
Ottum, J. A.
Oudenhoven, R. C.
Quigley, L. D.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schibly, W. J.
Schmidt, E. S.
Schmidt, R. T.
Schultz, J. H.
Shea, D. W.
Shinners, G. M.
Stauff, G. R.
Stiennon, O. A.
Stoll, W. M.
Sullivan, Donel
Theiler, G. J., Jr.
Theisen, J. K.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Warpinski, M. A.
Wochos, R. G.
Wunsch, C. A.
Zucker, K. L.

Greendale:
Brown, R. J.
Kuglitsch, E. F.
Onderak, E. P.

Green Lake:
Barbour, J. H.
Leininger, A. T.

Greenwood:
Olson, W. A.

Gresham:
Litzen, F. L.

Hales Corners:
Damiano, N. F.
Joseph, W. A.
Larsen, L. L.
La Susa, T. J.
Pierce, D. F.
Rath, E. K.
Richter, A. M.
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Hoffmann, J. G.
Hoffmann, W. C. P.
Kern, T. J.
Lehmann, F. W.
Monroe, M. E.
Quackenbush, E. C.
Quandt, V. V.
Sachse, F. W.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne
Shaffer, S. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Krueger, E. R.
Rosman, H. K.
Sahs, M. H.
Stang, H. M.
Wyant, M. E.

Hazel Green:
Klein, G. J.
Strauch, C. B.

Highland:
Shack, J. B.

Hillsboro:
Balder, R. E., Jr.
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.
Karsten, J. H.
Schulz, N. H.
Schutz, W. J.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.

Hurley:
Martinetti, D. J.

Hustisford:
Goetsch, O. F.

Independence:
Meyer, C. F.

Iola:
Knudsen, Else
Wiley, R. H.

Jackson:
Albrecht, J. E.

Janesville:
Bartels, G. W.
Baumgartner, M. M.
Betlach, Dorothy M.
Betlach, Eugene H.
Boutwell, W. S.
Clark, W. T.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Fitzgerald, G. P.
Frechette, F. M.
Freitag, S. A.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Holland, R. A.
Johnson, W. L.
Koch, V. W.
Lardinois, C. C.
Levin, Harland
Llewellyn, M. B.
McGuire, W. H.
McNichols, E. F.
McSweeny, A. J.
Metcalf, G. S.
Nash, C. B.
Neeno, Katsumi
Nolta, R. T.
Nuzum, T. O.
Odland, P. K.
Orear, Errell T.
Otterholt, E. R.
Overton, R. S.
Pember, J. F.
Peterson, Geo. H.
Purdy, M. F.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Sargeant, T. S.
Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Tarrasch, Hertha
Thomas, G. L.
Tordoff, J. J.
Welch, F. B.

Jefferson:
Brewer, J. C.
Busse, A. A.
Quandt, C. E.
Quandt, R. W.

Johnson Creek:
Wendt, F. A.

Juneau:
Ferguson, E. C.
Heath, H. J.

Kaukauna:
Bachhuber, A. E., Jr.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Skibba, J. P.

Kenosha:
Altman, J. S.
Ambro, P. J.
Andre, E. F.
Armstrong, G. F.
Ashley, R. W.
Barnes, E. H., III
Bilak, R.
Binnie, Helen A.
Bjork, H. A.
Block, R. M.
Bode, M. J.
Bonell, B. T.
Burnett, R. G.
Creighton, L. H.
Creswell, C. M.
Currie, R. E.
Davin, C. C.
Davis, D. W.
Davison, T. H.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Garren, J. T.
Goldstein, D. N.
Graves, J. P.
Hatfield, M. E.
Hauschild, W. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Mayfield, A. L.
Meeter, U. L.
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Olsman, Louis
Pearson, J. B.
Pechous, C. E.
Pechous, Lillian
Powell, R. A.
Randall, A. J.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rufflo, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.

Siegel, Morris
Swift, W. J., Jr.
Turner, Lewis, III
Ulrich, C. F.
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wood, Fredrick, Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Lanier, A. S.
Lanier, Patricia A.
Nesemann, R. M.
Wits, E. W.

Kiel:
Nauth, D. F.
Theiler, A. C.
Twohig, G. J.

Kimberly:
Curtin, D. W.
Gage, Ralph S.

Kohler:
Gascoigne, C. C.
Rowe, D. M.

La Crosse:
Aiken, R. E.
Alvarez, U.
Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
Bach, A. C.
Britt, A. G.
Buchman, D. M.
Carlsson, E. S.
Cejpek, K. O.
Cook, A. A.
Corser, D. H.
Daley, D. M.
Dalton, R. M.
Dietz, P. C.
Doyle, D. F.
Durst, J. B.
Egan, G. J., Jr.
Egan, J. F.
Ellenz, G. B.
Ernst, F. W.
Fisher, A. L.
Fox, J. C.
Gallagher, E. E.
Gallagher, F. J.
Gallagher, W. B.
Gatterdam, P. C.
Getz, Kaare
Gilbert, R. L.
Gilles, Paul L.
Gorenstein, L. M.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, G. A.
Gundersen, Gunnar
Gundersen, S. B.
Gundersen, S. B., Jr.
Gundersen, T. E.
Harman, J. C.
Hayden, J. W.
Helliesen, P. J.
Hickey, A. W.
Higgins, C. K.
Himmelsbach, W. A
Hulick, P. V.
Jensen, Alfhild
Jones, W. J.
Joseph, L. G.
Kalfayan, Bernard
Leiby, R. W., Jr.
MacEwen, A. R.
Mansheim, B. J.
McCann, John P.
McGarty, M. A.
McMahon, R. E.
McNamara, T. B.
Midelfort, C. F.
Murphy, G. B., Jr.
O'Meara, M. T.
Pauly, James P.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Scheurich, Mary B.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Sevenants, J. J.
Simones, J. J.
Simonson, S. W.
Sivertson, Martin
Sivertson, S. E.
Skemp, F. C.
Skemp, G. E.
Skemp, J. J.
Skemp, J. T.
Slungaard, Rolv
Thompkins, D. G.
Uhrich, G. I.
Voss, E. C., Jr.
Watunya, M. J.
Wolf, F. H.
Whiteway, R. E.

Ladysmith:
Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

Lake Geneva:
Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:
Eck, G. E.
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.
Turcott, R. A

Lancaster:
Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.

Land O'Lakes:
Eickhoff, E. C.

Laona:
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose, J. F.

Little Chute:
Van Lieshout, F. X.

Lodi:
Groves, R. J.
Irwin, W. G.

Loyal:
Hable, A. P.

Luxemburg:
Majeski, H. E.
Rahr, H. C.

Madison:
Aageson, C. W.
Ainslie, R. B.
Albright, E. C.
Allen, J. C.
Allen, J. R.
Allin, R. N.
Anderson, A. D.
Anderson, Jeanne
Anderson, R. B.
Angevine, D. M.
Ansfield, F. J.
Aronson, Abraham
Ashman, H. C.
Barks, M. F.
Bamforth, Betty J.
Barreto, R. S. A.
Bartlett, W. H.
Becker, R. M.
Beilman, R. L.
Belknap, E. L., Jr.
Benish, G. A.
Bennett, Maxine
Bentley, J. E.
Berg, Mary C.
Berger, J. V., Jr.
Bernard, F. D.
Bessire, M. C.
Blair, A. J.
Blum, F. G., Jr.
Bogle, W. C.
Bohlman, D. C.
Boldon, E. I., Jr.
Borenz, H. F.
Bothum, R. J.
Bowers, J. Z.
Brew, Barbara A.
Brindley, B. I.
Britton, D. M.
Brodhead, Wm. T.
Brown, Henry
Brucker, E. A.
Bruno, D. S.
Bujard, R. S., Jr.
Burke, C. F.
Burke, Mead
Burke, Myra E.
Burnett, G. H.
Burns, E. M.
Burns, R. E.
Buxbaum, R. C.
Calvert, Charlotte
Campbell, R. E.
Carter, H. M.
Chase, S. L.
Clatanoff, D. V.
Clausen, N. M.
Collins, J. D.
Collins, R. F.
Connors, D. M.
Cooksey, R. T.
Cookson, D. U.
Cooper, G. A.
Coryell, J. L.
Cowle, A. E.
Crocker, L. G.
Crowley, W. P., Jr.
Crummy, A. B., Jr.
Crumpton, C. W.
Curreri, A. R.
Curtis, J. K.
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Davidson, P. L.
Davis, A. W.
Davis, F. A.
Davis, F. J.
Davis, M. D.
Dean, F. K.
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Demergian, Vaughn
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Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Doehlert, C. A., Jr.
Dollard, J. E.
Domine, A. Z.
Doolittle, J. W.
Dudiak, Stephen
Duehr, P. A.
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Ellis, J. C., Jr.
Erickson, M. T.
Erickson, T. C.
Evans, A. S.
Ewell, G. H.
Farrell, R. X.
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Fellner, C. H.
Flinn, John H.
Forster, F. M.
Foseid, Oscar F.
Fosmark, C. A.
Foster, M. A.
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Frank, Jordan
Fritz, R. J.
Gale, J. W.
Ganser, L. J.
Garnett, G. M.
Gearhart, R. S.
Geppert, T. V.
Giles, L. T.
Glover, B. H.
Golden, F. F.
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Gordon, E. S.
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Greeley, H. P.
Gruesen, R. A.
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Guildner, C. W.
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Hamel, Merle O.
Handa, Yoshio
Hank, G. C.
Harper, C. S.
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Harris, R. C.
Hartridge, T. L.
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Hennen, R. J.
Hibma, O. V.
Hill, N. A.
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Hoff, A. D.
Hogan, L. H.
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Hunter, Amy Louise
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Inhorn, S. L.
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Javid, Manucher
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Keepman, Jay P.
Kemp, T. S.
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Kline, Joyce C.
Klumper, Wilhelm
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Lange, R. D.
Larson, F. C.
Lemmer, K. E.
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Lewis, W. C.
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Marlow, Gordon V.
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Mohs, F. E.
Monson, S. D.
Moore, J. N.

Morledge, John
Mortensen, O. A.
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Mussey, W. C.
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Oakley, Dorothy W.
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Olson, R. W.
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Orth, O. S.
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Parks, H. K.
Parsons, W. B., Jr.
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Podruch, P. E.
Pohle, E. A.
Preizler, Josef
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Prouty, L. R.
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Puestow, K. L.
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Rahm, J. P., Jr.
Rankin, John
Rapkin, M. A.
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Reese, H. H.
Reznichek, C. G.
Richtsmeier, A. J.
Ris, Hania W.
Roberts, L. M.
Rock, William
Roemer, E. P.
Rogers, S. C.
Roisum, B. H.
Rotter, Royal
Rounds, W. M.
Rowe, G. G.
Rusch, K. H.
Ryder, E. K., Jr.
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Salick, J. A.
Samp, R. J.
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Schmidt, C. S.
Schmitz, R. C.
Schneiders, E. F.
Schoenenberger, A. P.
Schoenwetter, C. D.
Schroeder, J. M.
Schubert, C. K.
Schultz, A. E.
Schwittay, Addie M.
Scott, J. K.
Shapiro, H. H.
Shideman, F. E.
Shropshire, R. W.
Shumate, J. K.
Siebecker, K. L., Jr.
Sims, J. L.
Sinaiko, R. P.
Sisk, I. R.
Skroch, E. E.
Smith, D. B.
Smith, Max M.
Smyth, I. P.
Sonneland, A. M., Jr.
Sprague, J. T.
Sprague, L. V.
Starr, C. R.
Stebbins, G. G.
Stehr, A. C.
Stiennon, O. A., Jr.
Stoerker, Ruth A.
Stoops, C. W.
Stovall, W. D.
Straughn, R. A.
Stuesser, G. J.
Suckle, H. M.
Taborsky, C. R.
Talbot, J. R.
Tanner, W. A.
Tenney, H. Kent, Jr.
Tenney, Horace K., III
Thompson, H. G., Jr.
Thornton, Madeline J.
Tormey, A. R.
Tormey, T. W., Jr.
Toussaint, J. B.
Trump, P. L., Jr.
Turgeson, J. H.
Tweeten, J. K.
Tybring, G. B.
Urben, W. J.
Van Duser, A. L.
Van Gemert, J. G.
Vanstane, V. K.
Vastola, A. P., Jr.
Vermund, Halvor
Vingom, C. O.
Vogel, Heinz
Vogt, G. H.
Waddell, J. G.
Walsh, E. G.
Walsh, L. G.
Walton, J. D.
Ward, V. G.
Washburn, W. L.
Washburne, Annette C.
Waskow, W. L.
Wasserburger, R. H.
Waters, D. D.
Wear, J. B.
Wear, J. B., Jr.
Weatherhogg, C. R.
Weinstein, A. B.
Welke, E. G.
Werrell, W. A.
Weston, F. L.
Wheeler, R. M.
Whitsitt, R. E.
Wilkie, J. M.
Williams, D. L.
Winston, Frank
Winston, Margaret C.
Wirig, M. H.
Wirka, H. W.
Wixson, R. C.
Wolberg, W. H.
Wong, H. C.
Worley, Gordon, Jr.
Wylde, R. M.
Ylitalo, W. H.
Young, W. P
Zimmer, R. W., Jr.

Manitowoc:

Arnold, T. S.
Banker, R. J.
Belson, H. J.
Bonner, N. A.
Davis, N. S., Jr.
Erdmann, N. C.
Evensen, N. A.
Hammond, F. W.
Hammond, R. W.
Hoffman, G. M.
Lynch, J. D.
MacLean, C. R.
Perry, T. K.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rauch, W. A.
Rees, T. H.
Sargeant, C.
Schaefer, H. E.
Scherping, W. H.
Shaw, Jesse W., Jr.
Simon, G. M.
Smejkal, W. F.
Sobush, L. D.
Stannard, G. H., Jr.
Steckbauer, J. W.
Strong, R. G.
Teitgen, T. A.
Thorpe, R. F.
Wall, C. E.
Webster, J. G.
Yost, R. G.

Marathon:

Kampine, C. E.
Klein, T. W.

Maribel:

May, J. H.

Marinette:

Bell, J. M.
Boren, C. H.
Boren, Clark H.
Boren, J. A.
Boren, J. W., Jr.
Koepp, C. E.
Moss, K. J.
Pinegar, K. G.
Zeratsky, J. D.

Markesan:

Cupery, D. P.
Plueddeman, P. M.

Marshall:

Schmidt, C. W.

Marshfield:

Baldwin, Elizabeth
Baldwin, R. S.
Bodmer, R. E.
Bowerman, C. I.
Burns, J. L., Jr.
Custer, G. S.
Doege, K. H.
Doege, P. F.
Dye, R. A.
Emanuel, D. A.
Epstein, Stephan
Glassy, F. J.
Glumy, P. R.
Gouze, F. J.
Griese, G. G.
Heersma, J. R.
Helland, N. J.
Heywood, R. M.
Heywood, W. H.
Larkin, W. B.
Lawton, B. R.
Lewis, R. F., Jr.
Lohrenz, F. N.
Macht, A. J.
Magnin, George E.
Manier, J. W.
Mason, R. W.
McCormick, G. L.
McKenty, J. D.
Olsen, T. G.
Osborne, J. V.
Ousley, J. L.
Pederson, D. P.
Potter, R. P.
Pyka, R. A.
Rice, T. J.
Rowe, R. J.
Rupel, J. W.
Salibi, B. S.
Schloesser, L. L.
Suits, J. J.
Taylor, R. D.
Vedder, C. A.
Vedder, J. S.
Waters, H. S.
Wickham, J. M.
Williams, G. H.
Wink, R. H.

Mauston:

Griffin, V. M.
Hess, J. S., Jr.
Strong, Jack
Tverberg, M. S.
Vedner, J. H.

Mayville:

Bachhuber, F. G.
Parish, G. A.
Royce, M. E.

Mazomanie:

Schultz, Isadore

Medford:

Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Mellen:

Lockhart, C. W.

Menasha:

Buran, D. J.
Conway, J. E.
De Morest, H. F., Jr.
Forkin, G. E
Hildebrand, G. B.
Hildebrand, W. B.
Jensen, F. G.
Jensen, R. A.
Nebel, J. R.
Pratt, G. N., Jr.
Schwei, G. P.
Wainscott, P. E.

Menomonee Falls:

Domann, W. A.
Domann, W. G.
Harrington, K. J.
Heyrman, D. J.
Leenhouts, K. C.
Mataicka, W. E.
Nickels, R. J.
Schloemer, H. F.
Schmidt, J. R.

Menomonie:

Belza, Janusz
Buckley, C. H.
Crippen, D. A.
Drescher, A. A.
Halgren, J. A.
Lee, S. R.
Lumsden, William
McMahon, A. E.
Nolan, J. L., Jr.
Quilling, P. A.
Tweeten, J. B.

Mequon:

Kim, K. S.
Schulz, H. F. W.

Mercer:

Hogan, John
Kleinboehl, J. W.

Merrill:

Bayer, L. J.
Bayer, W. H.
Bigalow, J. F.
Braun, W. E.
Kelley, F. H.
Lane, F. C.
Lewinnek, Walter
Millenbah, J. D.
Morris, K. A.
Ravn, E. O.
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Middleton:

Gollin, F. F.
Heighway, T. F.
James, J. R.
Kreutzer, E. W.
Stricker, M. F.

Milton:

Burdick, H. L.
Davis, M. D.
Lyons, R. P.

Milton Junction:

Holmes, J. F.
Klein, T. W.

Milwaukee:

Ackerman, E. J.
Ackerman, J. S.
Adamkiewicz, J. J.
Adlam, R. T.
Aguirre, M. R.
Albrecht, D. J.
Altshuler, C. H.
Amberg, John
Ansfield, D. J.
Apfelberg, H. J.
Aquino, Manuel
Armbruster, J. L.
Asma, R. M.
Askot, M. M.
Atkinson, C. T.
Atkinson, W. T.
Ausman, D. C.
Ausman, H. R.
Avellone, B. M.
Aylward, T. J.
Babbitt, D. P.
Babbitz, A. L.
Babbitz, S. G.
Babby, Louis
Bach, M. J.
Bachhuber, E. A.
Bachman, C. H.
Backus, E. A.
Baier, A. R.
Baird, W. W.
Baker, V. L.

Balistreri, Frank
Bardenwerper, H. E.
Bareta, John
Barnett, S. M.
Baron, J. J.
Barrock, J. J.
Barta, E. F.
Barta, R. F.
Bauch, N. G.
Bauer, C. A.
Bauman, R. O.
Baumgart, C. H.
Baumle, B. J.
Baylon, V. A.
Bechmann, Fred
Becker, Barney B.
Becker, I. M.
Becker, J. F.
Beckman, Harry
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Behnke, E. J.
Belfus, F. H.
Belknap, E. L.
Bellehumeur, C. E. P.
Bender, B. I.
Benjamin, H. B.
Bensman, L. L.
Bercey, J. E.
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Berk, R. A.
Berlow, Stanley
Berman, Alexander
Berner, C. L.
Bernhard, G. C.
Bernhard, L. A.
Bernhard, V. M.
Bernhart, E. L.
Bernstein, H. H.
Berridge, F. E., Jr.
Beutler, A. D.
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Biller, J. H.
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Black, S. B.
Blanchard, H. H.
Blankstein, S. S.
Bleil, D. C.
Blount, W. P.
Bodden, A. M.
Boger, J. N.
Bogost, Bruce
Bolger, J. V.
Bolton, R. L.
Bonan, J. D.
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Bookhamer, J. W.
Borman, M. C.
Bornstein, Max
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Boulanger, W. J.
Bourne, N. W.
Boxer, L. M.
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Boyd, Andrew, Jr.
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Bremer, E. M.
Brennan, J. J.
Brewer, B. J.
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Brillman, C. R.
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Brunkhorst, R. O.
Bruns, W. T.
Brzezinski, E. A.
Budny, C. L.
Bugarin, N. L.
Buggy, W. J.
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Burchman, S. L.
Burgess, G. F., Jr.
Burris, B. C.
Busby, W. W.
Buscaglia, A. T.
Buscaglia, C. J.
Bussey, A. D.
Buszkiewicz, T. S.
Byrne, R. W.
Caine, Donald
Callahan, J. W.
Callan, P. L.
Callan, R. E.
Calvy, T. L.
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Carlson, D. J.
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Casey, J. H.
Cash, I. I.
Casper, W. T.
Cassidy, R. H.
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Chase, Jules
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Collopy, P. J.
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Cox, J. A.
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Craite, E. J.
Cron, R. S.
Crottier, C. J.
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Baumle, C. E.
Bear, N. E.
Brunkow, B. H.
Cales, J. O.
Chandler, Arthur, Jr.
Duluc, L. G.
Eckstam, E. E.
Fencil, W. J.
Frantz, J. A.
Irvin, J. M.
Kindschi, L. G.
Kundert, F. W.
Miller, C. O.
Mings, D. E.
Moore, L. A.
Murray, J. F.
Olson, M. J.
Springer, D. W.
Staab, W. J., Jr.
Stiles, F. C.
Stormont, J. R.
Weir, J. R.
Wichser, R. F.
Witte, K. B.
Zach, R. G.
Zupanc, E. A.

Montello:
Federman, E. H.
Inman, R. F.

Montfort:
Breier, H. P.

Monticello:
Stovall, W. D., Jr.

Montreal:
Pierpont, J. M.

Mosinee:
Knoedler, W. H., Jr.

Mount Calvary:
Miller, J. F.
Stella, J. L.

Mount Horeb:
Morrison, M. T.

Mukwonago:
Kern, E. E.
Rosenkranz, W. E.
Zwisler, E. E.

Muscoda:
Ackerman, E. T.
Klockow, W. E.

Muskego:
Buhl, J. L.
Kelm, G. J.

Neenah:
Anderson, G. R.
Arndt, G. W., Sr.
Beatty, S. R.
Beglinger, H. F.
Bonfiglio, R. G.
Brown, R. C.
Brunckhorst, F. O.
Canavan, J. P.
Colgan, H. J.
Graham, A. P.
Hardie, G. H.
Haselow, J. R.
Henning, R. E.
Kirchgeorg, Clemens
Pansch, F. N.
Petersen, G. W.
Quade, R. H.
Regan, D. M.
Ryan, D. J.
Schwab, R. L.
Smith, F. H.
Springer, V. G.
Suechting, R. L.
Talbot, A. E.

Neillsville:
Manz, K. F.
Overman, M. V.
Rosekrans, M. C.
Rosekrans, Sarah D.
Thompson, T. N., Jr.

Nekoosa:
Jerofke, Alfred
Pfeiffer, L. R.
Thompson, J. E.

New Berlin:
De Vault, M. L.
Hartwick, J. P.
Komar, R. R.
Schofield, Raymond
Selle, F. S.

New Franken:
Looze, J. A.

New Glarus:
Hicks, E. V.
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F. P.

New Lisbon:
Koch, C. B
Weston, C. L.

New London:
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Craig, J. L.

Davis, R. R.
Drury, E. M.
Epley, O. H.
Healy, J. P.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oconomowoc:
Burch, R. N.
Claude, J. L.
Driscoll, L. J
Epperson, D. P.
Frank, E. B.
Gallo, G. L.
Goral, T. J.
James, W. D.
Janssen, W. C.
Loughnan, A. J.
Matt, J. R.
Miller, G. D.
Nammacher, T. H.
Rheineck, A. F.
Rogers, A. F.
Schuele, D. T.
Schumacher, B. J.
Schumacher, J. P.
Stemper, Irene T.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Aageson, H. A.
Zantow, F. E.

Oconto Falls:
Culver, J. R.
Siefert, C. E

Omro:
Peck, D. D.
Schoenbechler, L. J.

Onalaska:
Gray, R. H.
Reay, G. R.
Van Susteren, J. A.

Oregon:
Dukerschein, F. N.
Johnson, E. S.
Kellogg, L. S.

Orfordville:
McNair, E. R.

Osceola:
Cramer, G. A.
Simenstad, L. O.
Weller, L. J.

Oshkosh:
Apell, M. G.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Clark, W. E.
Connell, F. G.
Cummings, E F.
Danforth, H. J.
Danforth, Q. H.
Enrich, P. S.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Guenther, O. F.
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Haubrick, H. J.
Hillenbrand, H. M.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Leibenson, S. J.
Leschke, John A.
Meilicke, C. A.
Meli, J. V.
Monday, Harvey
Petersik, J. T.
Pfefferkorn, E. B.
Romberg, H. A.
Scheuermann, N. M.
Steele, G. A.
Steen, M. H.
Stone, L. H.
Strakosch, E. A.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Winter, E. F.
Wolfgram, R. C.
Wright, E. N.
Zmolek, E. J.

Osseo:
Knutson, Oscar

Palmyra:
Handeyside, R. G.

Pardeeville:
Westcott, T. S.
Winkler, H. A.

Park Falls:
Enzinger, Josef
Leahy, J. D.
Murphy, J. L.

Peebles:
Menne, F. R.

Pell Lake:
Roenau, Elly A.

Peshtigo:
Barrette, Antoine
Blahnik, C. L.

Pewaukee:
Egloff, L. W.
Kelly, J. P.

Phelps:
Wolcott, R. R.

Phillips:
Niebauer, W. E.
Rens, J. L.

Plain:
Fowler, Paul H.
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Cunningham, Wilson
Doeringsfeld, H. L.
McCumber, M. L.
Moffett, J. L.
Steidinger, C. L.

Plymouth:
Brickbauer, A. J.
Dietsch, L. C.
Evers, R. H.
Mueller, J. F.
Radloff, A. C.
Steffan, L. J.
Weisse, H. A.

Portage:
Cooney, R. T.
Henney, C. W.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.

Port Washington:
Barr, A. H.
Henkle, R. F.
Kauth, C. P.
Muehlhaus, F. R.
Savage, G. F.
Swingle, J. D.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.
Stevenson, D. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Satter, O. E.
Shapiro, H. L.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Trautmann, Milton
Zauft, G. W.

Prairie Farm:
Roemhild, F. N.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Brusky, S. F.
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Alexander, A. C.
Bacon, G. A.
Barina, H. J.
Barnes, R. O.
Bennett, W. H.
Bliwas, Arnold
Brehm, H. G.
Brewer, G. W.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Burke, Donald
Christensen, F. C.
Christenson, C. W.
Constantine, C. E.
Cook, J. C.
Covell, K. W.
DeGroot, H. E.
Dockery, J. N.
Docter, J. C.
Dorman, T. W.
Edwards, A. C.
Faber, S. J.
Fazen, L. E.
Fazen, L. E., Jr.
Fogle, R. J.
Fralich, J. C.
Gradetto, P. A.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Harris, W. C.
Hemmingsen, T. C.
Henken, J. F.
Henken, W. F.
Hilker, H. C.
Hilpert, F. M.
Hogan, J. H.
Holman, J. H.
Jacobsen, A. J.
Jamieson, J. G.
Johnson, P. S.
Jones, Beatrice O.
Jones, L. E.
Kaarakka, O. F.
Kadin, Maurice
Kehl, K. C.
Keland, H. B.
Konnak, Wm. F.
Kreul, R. W.
Kreul, W. R.
Kurten, L. J.
Kurten, R. M.
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Lifschutz, L. M.
Lindner, A. M.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Madden, W. J.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Newman, C. R.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Petersen, J. J. G.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schatz, W. R.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Smullen, G. H.
Steffen, Elizabeth A.
Stika, E. A.
von Jarchow, B. L.
Walters, H. G.
Williamson, W. H.
Wright, R. S.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Stadel, E. V.
Tibbitts, J. A.

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Haug, Thomas M.
Johnson, A. G.
Mescher, T. J.
Nik Nevin, Ismail
Osborne, R. R.
Pratt, G. F.
Rosemeyer, O. G.
Schiek, I. E.
Schiek, I. E., Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
Engels, E. P.
Kristensen, L. A.
Maser, J. F.
McKenzie, J. R., Jr.
Rydell, O. E.
Rydell, W. B.

Richland Center:
Crandall, G. H.
Edwards, W. C.
Glise, Roy C.
Hinke, D. H.

Housner, R. E.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Sholtes, C. A.
Spear, Jack
Taft, D. J.

Rio:
Langmack, W. A.
Maas, W. C.

Ripon:
Bachus, A. C.
Cole, D. F.
Dittmer, O. A.
Johnson, J. M.
La Ham, J. T.
Pelton, R. S.
Schuler, W. H.
Sundeen, R. A.

River Falls:
Cairns, R. U.
Grassl, F. O.
Gutzler, P. H.
Hammer, R. M.
Haskins, P. S.

Rosholt:
Benn, V. A.

St. Croix Falls:
Belshe, J. C.
Ericksen, D. M.
Fink, D. W.
Olson, L. L.
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Nazianz:
Foley, M. E.

Sauk City:
Bachhuber, H. A.
Kraus, B. F.
Walsh, T. W.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Schrock, J. B.

Shawano:
Arvold, D. S.
Cantwell, A. A.
Cantwell, R. C.
Coon, W. A.
Jeffries, Donald A.
Laufenburg, H. F.
Marsh, H. C.
Peterson, L. W.
Sebesta, A. J.
Von Ruden, W. J.

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Bock, A. B. C.
Bringe, J. W.
Cinelis, Ann A.
Dick, H. J.
Eckardt, B. F.
Evenson, N. A.
Graf, C. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, G. J.
Hildebrand, J. F.
Hoon, J. R.
Houfek, E. E.
Hougen, E. T.
Huibregtse, W. G.
Jaeck, J. L.
Jumes, M. G.
Keller, R. A.
Knauf, A. J.
Kolb, F. K.
Kovacic, J. F.
Marsho, B. S.
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Michael, J. D
Moir, Jane M.
Moir, W. W.
Mooney, F. L.
Nause, F. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Schlichting, J. E.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A.
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Tompsett, A. C.
Van Driest, J. J.
Weber, C. J.
Werner, D. A.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Leighton, F. A.
Weygandt, J. L.

Shell Lake:
Flogstad, Duane
Moen, D. V.
Welter, D. J.

Shiocton:
La Croix, G. M.

Shorewood:
Vlagny, F. J.

Shullsburg:
Garland, D. J.
Gratiot, Mary P.
Hoesley, H. F.

Silver Lake:
De Witt, C. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Murphy, G. V.
Oberfeld, H. H.
O'Leary, W. J.
Theisen, C. E.
Turgai, Valerio
Zahl, W. H.

South Wayne:
Creasy, L. E.

Sparta:
Beebe, D. C.
Beebe, S. D.
Brown, J. D.
Harris, A. J.
Lukasek, E. O.
Mannis, Harry
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Valley:
Docter, C. W.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Overgard, A. W.

Stevens Point:
Anderson, G. H.
Anderson, H. A.
Benn, H. P.
Bickford, R. H.
Crosby, E. P.
Dunn, A. G.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Grinvalsky, H. T.
Iber, F. C.
Kohn, A. M.
Litzow, J. A.
Miller, S. R.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Sanders, R. H.
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stoughton:
Hermundstad, O. A.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Brook, J. J., Jr.
Dorchester, D. E.
Grota, H. D.
Hobson, W. S.
Muehlhauser, J. O.
Murphy, J. T.
Sheets, W. G.

Sun Prairie:
Behrend, J. F.
Grab, J. A.
Nelson, E. J.
Peterson, Leo W.
Roley, E. L.
Russell, W. T.

Superior:
Aktekin, Hikmet
Anderson, R. T.
Carpenter, E. E.
Doyle, T. J.
Droege, C. T.
Ekblad, V. E.
Finn, Milton
Foderick, J. W.
Fruehauf, R. P.
Giesen, Conrad W.
Heisel, J. G.
Johnson, F. G., Jr.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mataczynski, R. R.
McGill, J. W.
McGinnis, J. P.
Picard, C. J.
Rosin, L. R.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T.
Weisberg, J. H.

Suring:
Sandgren, G. R.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, G. P.

Thiensville:
Elbe, T. D.
Herman, Murray
Levy, E. S.

Thorp:
Jorgensen, Eleanora F.
Jorgensen, P. B.
Neis, F. P.

Tigerton:
Heise, L. F.

Tomah:
Bryan, A. J.
Konicek, R. G.
Kozarek, C. E.
Landmann, G. A.
Mubarak, J. S.

Tomahawk:
Baker, G. R.
Baker, R. G.
Henderson, R. J.
Jarvis, D. F.
Jarvis, E. C.
McCormick, W. C.
Rouman, W. C.

Turtle Lake:
Halberg, A. C.

Two Rivers:
Kaner, S. L.
Kozelka, A. W.
Kuljis, D. A.
Martin, R. E.
Weld, S. L.
Zlatnik, A. P.

Union Grove:
Haedike, W. D.
McCracken, R. W.
McGinnis, H. J.
Schulz, G. J.
Winter, R. V.

Valders:
Acheson, W. E.
James, R. L.

Verona:
Noll, D. J.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Skinsnes, C. C.
Starr, R. A.
Syty, Joseph
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Wabeno:
Tenley, O S.

Walworth:
Bruhn, I. J.
Church, Ruth E.
Coon, W. W.
Kroyer, T. J.

Washburn:
Guzzo, Harold

Waterford:
Bardenwerper, H. W.
Dietz, R. J.

Waterloo:
Fowler, J. R.
Garman, J. S.
Kennedy, F. H.

Watertown:
Baldwin, R. C.
Becker, J. H.
Burzynski, E. E.
Hahn, A. C.
Miller, E. A.
Schuh, E. P.
Zimmermann, F. H.

Waukesha:
Alston, J. A.
Bartos, J. A.
Bartos, R. E.
Bischel, J. R.
Bolger, James V.
Brown, W. E.
Campbell, P. E.
Campbell, W. B
Carroll, P. E.
Clothier, W. J. K.
Davies, E. B.
Davies, Gwilym
Dugan, T. E.
Edmondson, C. C.
Edson, J. D.
Elson, C. E.
Feulner, R. C.
Frantz, R. G.
Gantz, H. A.
Gilbert, Francis
Guy, J. R.
Kaschat, R. L.
Kritter, A. E.
McDonell, T. H.
Merkow, William
Monk, R. S.
Motzel, A. J., Jr.
Promer, J. E.
Schmidt, C. W.
Schulz, E. G.
Settlage, H. A.
Smirl, W. G.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A.
Weis, T. W.
Werra, B. J.
Werra, M. J.
Wood, C. A.
Zietlow, F. G.

Waunakee:
Marquis, W. R.

Waupaca:
Boudry, M. O.
Haman, K. L.
Salan, Sam
Steiner, J. H.

Waupun:
Barajas, Rafael
Hebenstreit, A. J.
Hull, H. H.
Larimore, O. M.
Petters, W. J.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

Wausau:
Andrews, G. R.
Bachhuber, G. J.
Balliet, C. M.
Bartholomew, R. D.
Becker, W. T.
Brick, E. B.
Brodhead, R. H.
Burby, J. J.
Burr, Thurl C., Jr.
Christensen, H. W.
Davis, Helen Crawford
Fechtner, H. H.
Flannery, J. V.
Flemming, E. E.
Foerster, J. M.
Freeman, D. J.
Freeman, J. M.
Gargas, B. L.
Grauer, C. G.
Green, D. M.
Hammes, G. R.
Hendrickson, A. O.
Hendrickson, W. O.
Hoessel, A. W.
Johnson, F. C.
Jones, M. L.
Juers, R. H.
Kass, R. M.
Kelley, O. R.
Kline, C. L.
Kordiyak, George
Kramer, J. D.
Larsen, R. B.
Locher, W. G.
Ludwig, E. P.
Mallery, O. T.
McCandless, E. E.
Miller, W. C.
Molinaro, A. J.
Norton, W. I.
Peterson, T. H.
Prehn, F. C.
Rudy, W. B.
Schroth, G. J.
Shannon, R. C.
Shaw, W. R.
Smith, B. K.
Smith, S. M. B.
Songe, R. A.
Stahmer, A. H.
Stahmer, K. H.
Stevens, G. H.
Struthers, J. L.
Thackeray, R. C.
Thorgersen, T. M.
Trumbo, J. K.
Williamson, L. M.
Wilson, O. M.
Yoran, C. M.

Wautoma:
Beck, A. A.
Darby, R. C.
Shemanski, L. S.
Slattery, F. G.

Wauwatosa:
Appleby, K. B.
Arneth, J. J.
Baker, W. V.
Beck, K. H.
Beltran, D. J.
Bemmann, Kathryn C.
Berglund, G. A.
Boyle, R. W.
Brandt, E. F.
Brault, R. G.
Brook, J. J.
Burgardt, G. F.
Cadden, A. V.
Calvy, D. W.
Coon, H. M.
Curtis, William C.
Dettmann, N. F.
Dohearty, W. H.
End, Edgar
Engstrom, W. W.
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Flanary, J. R.
Gunderson, D. E.
Harkness, John W.
Headlee, C. R.
Higley, R. A.
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Josephson, Morton
Kebbekus, R. A.
Kehlnhofer, F. H.
Klopfer, W. P.
Kocovsky, E. C.
Kradwell, W. T.
Liefert, K. A.
Lorton, W. L.
Malloy, P. J.
Marck, Abraham
McDermott, J. F.
McGrath, D. J.
Modaff, W. L.
Nordin, P. F.
O'Connell, James R.
Osgood, C. W.
Patterson, R. H.
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Pfeffer, T. J.
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Seifert, K. A.
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Schmidt, E. J.
Stuhler, J. D.
Turrell, E. S.
Twelmeyer, H. F.
Winters, K. J.
Wood, D. L.

Webster:
Maas, D. A.

West Allis:
Bemis, E. L.
Bertolaet, E. E.
Biljan, M. W.
Brumbaugh, E. V.
Collins, E. G.
Couch, J. R.
Couch, T. T.
Cramer, R. P.
Everts, E. L.
Frederick, R. H.
Fulton, J. W.
Heinan, F. C.
Hermann, W. C.
Jochimsen, M. A.
Malensek, M. C.
Mallin, Isadore
Miner, D. L.
Nefches, M. S.
Ohlsen, M. P.
Rumhoff, Gordon
Smits, R. H.
Stamm, M. P.
Stern, C. S.
Stern, L. S.
Stern, R. S.
Stubenrauch, G. O.
Toepfer, R. A.
Wakefield, G. F.
Wilkinson, E. D.
Wilkinson, J. J.
Zenz, Carl
Zimmer, J. F.
Zimmer, J. J.

West Bend:
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Baumgartner, J. F.
Bush, F. I.
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Frankow, R. O.
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Struck, Eleanor C.

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Lenz, R. B.

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Lloyd, B. E.
Morris, D. L.
Swarthout, Edyth C.
Wakefield, G. F.

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Otterson, W. N.

Westfield:
Fredrick, H. Y.

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Gruender, J. E. M.

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Wichmann, R. D.

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Denzel, H. A.
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Loftus, E. R.

Winneconne:
McDonald, D. H.

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Gissal, F. W.
Houghton, J. H.

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Arendt, N. W.
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Baker, H. P.

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Ballard, M. D.
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Dessel, B. H.
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Hartman, A. S.
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Stengel, B. F.
Tisone, J. J.

Woodruff:
Pfeiffer, O. W.
Hiatt, W. R.

Woodville:
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Wrightstown:
Vande Loo, F. B.

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Middleton, W. S. ---------- Washington, D. C.
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Simenstad, P. O. ---------- Minneapolis, Minnesota
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Brehm, H. J. ---------- Racine
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Cairns, R. U. ---------- River Falls
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Christensen, F. C. ---------- Racine
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Connell, F. G. ---------- Oshkosh
Crockett, W. W. ---------- Beloit
Cunningham, Wilson ---------- Platteville
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* Granted life membership in 1961.

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Gramling, J. J.----Milwaukee
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Herrington, R. E.----Milwaukee
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Knutson, Oscar----Osseo
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Moore, L. A.----Monroe
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8700 W. Wisconsin Avenue

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723 58th Street
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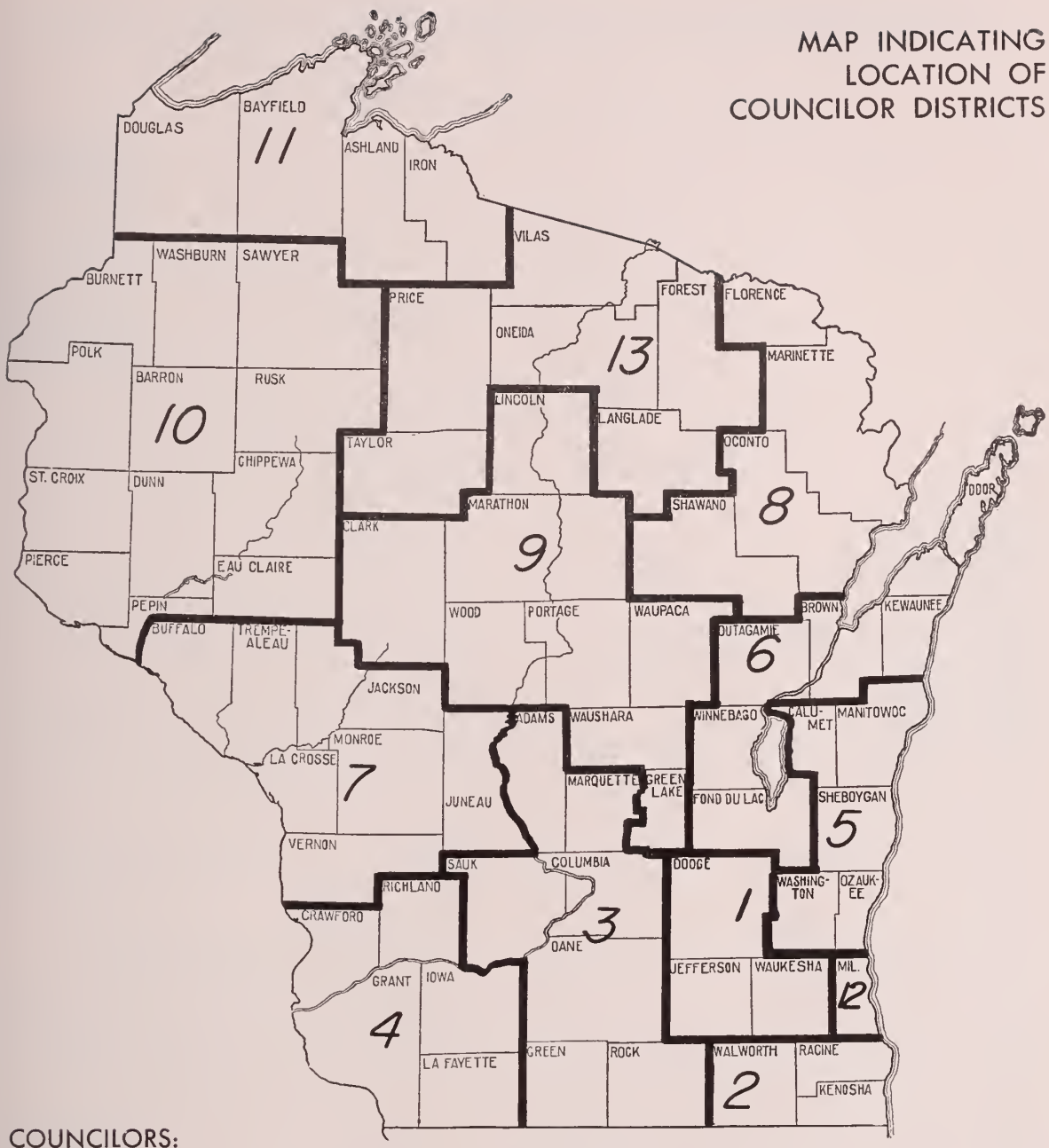
30 So. Henry Street

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



COUNCILORS:

FIRST DISTRICT:
W. D. James, M.D., Oconomowoc

SECOND DISTRICT:
G. J. Schulz, M.D., Union Grove

THIRD DISTRICT:
E. J. Nordby, M.D., Madison
J. H. Houghton, M.D., Wisconsin Dells

FOURTH DISTRICT:
E. M. Dessloch, M.D., Prairie du Chien

FIFTH DISTRICT:
P. B. Blanchard, M.D., Cedarburg

SIXTH DISTRICT:
H. J. Kief, M.D., Fond du Lac

SEVENTH DISTRICT:
J. C. Fox, M.D., La Crosse

EIGHTH DISTRICT:
J. M. Bell, M.D., Marinette

NINTH DISTRICT:
R. W. Mason, M.D., Marshfield

TENTH DISTRICT:
R. C. Frank, M.D., Eau Claire

ELEVENTH DISTRICT:
V. E. Ekblad, M.D., Superior

TWELFTH DISTRICT:
L. J. Van Hecke, M.D., Milwaukee
W. J. Houghton, M.D., Milwaukee
D. M. Willson, M.D., Milwaukee
W. J. Egan, M.D., Milwaukee

THIRTEENTH DISTRICT:
W. P. Curran, M.D., Antigo

Officers and Councilors 1961-1962

State Medical Society of Wisconsin

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723–58th Street

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304 West Washington Avenue

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330 East Lakeside Street

ASSISTANT SECRETARIES—Mr. Roy T. Ragatz, Madison
Mr. Earl R. Thayer, Madison
330 East Lakeside Street

TREASURER—F. L. Weston, M.D., Madison
1 South Pinckney Street

SPEAKER—Robert E. Callan, M.D., Milwaukee
1733 West Wisconsin Avenue

VICE-SPEAKER—H. W. Carey, M.D., Lancaster
257 Madison Street

COUNCILORS

(J. C. Fox, M.D., La Crosse, Chairman)
(J. M. BELL, M.D., Marinette, Vice-chairman)

DISTRICTS

FIRST: Dodge, Jefferson and Waukesha County Societies. W. D. James, M.D., 340 Summit Avenue, Oconomowoc, 1963.

SECOND: Kenosha, Racine and Walworth County Societies. G. J. Schulz, M.D., 722 16th Avenue, Union Grove, 1963.

THIRD: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. E. J. Nordby, M.D., 2715 Marshall Court, Madison, 1964; J. H. Houghton, M.D., Wisconsin Dells, 1963.

FOURTH: Crawford, Grant, Iowa, Lafayette and Richland County Societies. E. M. Dessloch, M.D., Medical Park, Prairie du Chien, 1964.

FIFTH: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. P. B. Blanchard, M.D., 204 North Washington Avenue, Cedarburg, 1964.

SIXTH: Brown, Door–Kewaunee, Fond du Lac, Outagamie and Winnebago County Societies. H. J. Kief, M.D., 104 South Main Street, Fond du Lac, 1964.

SEVENTH: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. J. C. Fox, M.D. (Chairman), 212 South Eleventh Street, La Crosse, 1962.

EIGHTH: Marinette–Florence, Oconto, and Shawano County Societies. J. M. Bell, M.D. (Vice-chairman), 516 Houston Street, Marinette, 1962.

NINTH: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Societies. R. W. Mason, M.D., 650 South Central Avenue, Marshfield, 1962.

TENTH: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. R. C. Frank, M.D., 550 North Dewey Street, Eau Claire, 1962.

ELEVENTH: Ashland–Bayfield–Iron and Douglas County Societies. V. E. Ekblad, M.D., 1507 Tower Avenue, Superior, 1963.

TWELFTH: The Medical Society of Milwaukee County. L. J. Van Hecke, M.D., 161 West Wisconsin Avenue, Milwaukee, 1963; W. J. Houghton, M.D., 2943 North Oakland Avenue, Milwaukee, 1963; D. M. Willson, M.D., 2618 East Shorewood Blvd., Milwaukee, 1964; W. J. Egan, M.D., 720 North Jefferson Street, Milwaukee, 1962.

THIRTEENTH: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. W. P. Curran, M.D., 700½ Fifth Avenue, Antigo, 1962.

PAST PRESIDENT—E. D. Sorenson, M.D., Elkhorn
104 South Wisconsin Street

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A. A. Quisling, M.D. (1963)—Madison
2 West Gorham Street

R. E. Galasinski, M.D. (1963)—Milwaukee
3333 South 27th Street

L. O. Simenstad, M.D. (1962)—Osceola
141 North Cascade

E. L. Bernhart, M.D. (1962)—Milwaukee
2714 West Burleigh Street

Alternates

W. B. Hildebrand, M.D. (1963)—Menasha
59 Racine Street

George Collentine, Jr., M.D. (1963)—Milwaukee
2266 North Prospect Avenue

John M. Bell, M.D. (1962)—Marinette
516 Houston Street

J. M. Sullivan, M.D. (1962)—Milwaukee
161 West Wisconsin Avenue

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* Map indicating location of councilor districts, page 77.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May.

Standing Committees—1961-1962

State Medical Society of Wisconsin

COMMITTEE ON CANCER

Paul M. Cunningham, M. D.
Chairman

Paul M. Cunningham, M.D. (1963) ——— Appleton
Chairman — 401 North Oneida Street

Robert S. Monk, M.D. (1963) ——— Waukesha
149 Wisconsin Avenue

J. R. Hoon, M.D. (1963) ——— Sheboygan
1011 North 8th Street

R. R. Mataczynski, M.D. (1963) ——— Superior
1514 Ogden Avenue

J. W. Boren, Jr., M.D. (1964) ——— Marinette
1510 Main Street

M. W. Stuessy, M.D. (1964) ——— Brodhead
605 East Fourth Avenue

G. H. Williams, M.D. (1964) ——— Marshfield
Marshfield Clinic

Ralph C. Frank, M.D. (1962) ——— Eau Claire
550 North Dewey Street

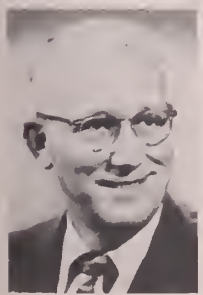
G. I. Uhrich, M.D. (1962) ——— La Crosse
212 South Eleventh Street

R. C. Glise, M.D. (1962) ——— Richland Center
118 West Mill Street

G. A. Smiley, M.D. (1962) ——— Delavan
107 North Third Street

J. J. Gramling, Jr., M.D. (1962) ——— Milwaukee
324 East Wisconsin Avenue

J. F. Brown, M.D. (1962) ——— Rhinelander
1020 Kabel Avenue



COMMITTEE ON GRIEVANCES

E. D. Sorenson, M.D.
Chairman

E. D. Sorenson, M.D. (1962) ——— Elkhorn
Chairman — 104 South Wisconsin Street

R. E. Fitzgerald, M.D. (1963) ——— Milwaukee
2218 North Third Street

K. A. Morris, M.D. (1963) ——— Merrill
705 East First Street

J. D. Leahy, M.D. (1963) ——— Park Falls
170 Fourth Avenue North

H. J. Belson, M.D. (1964) ——— Manitowoc
904A South Eighth Street

R. R. Richards, M.D. (1964) ——— Eau Claire
605 Walker Avenue

T. J. Nereim, M.D. (1964) ——— Madison
333 Glen Way

E. W. Mason, M.D. (1962) ——— Milwaukee
324 East Wisconsin Avenue

R. W. Mason, M.D. (1962) ——— Marshfield
650 South Central Avenue

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. E. Dorchester, M.D.
Chairman

D. E. Dorchester, M.D. (1963) ——— Sturgeon Bay
Chairman — 10 North Third Avenue

J. E. Martin, Jr., M.D. (1963) ——— Delavan
607 Walworth Avenue

G. M. Shinners, M.D. (1963) ——— Green Bay
P.O. Box 98

J. S. Devitt, M.D. (1964) ——— Milwaukee
944 North Jackson Street

Louis Olsman, M.D. (1964) ——— Kenosha
625 57th Street

C. A. Olson, M.D. (1964) ——— Baldwin

C. J. Picard, M.D. (1962) ——— Superior
425–21st Avenue, East

D. G. MacMillan, M.D. (1962) ——— Barron
1220 Woodland

W. E. Acheson, M.D. (1962) ——— Valders
Liberty Street

COMMISSION ON PUBLIC POLICY

R. G. Zach, M.D.
Chairman

Robert G. Zach, M.D. (1962) ——— Monroe
Chairman 810–19th Avenue
H. E. Oppert, M.D. (1962) ——— Viroqua
318 South Main Street
Earl C. Quackenbush, M.D. (1962) ——— Hartford
14 North Main Street
D. N. Goldstein, M.D. (1963) ——— Kenosha
723–58th Street
Norbert Enzer, M.D. (1964) ——— Milwaukee
948 North Twelfth Street
L. J. Kurten, M.D. (1965) ——— Racine
810 Main Street
J. F. McIntosh, M.D. (1966) ——— Madison
1219 Regent Street

President, ex officio
President-elect, ex officio
Secretary, ex officio

COMMISSION ON SCIENTIFIC MEDICINE

R. B. Larsen, M.D.
Chairman

R. B. Larsen, M.D. (1962) ——— Wausau
Chairman 510 Third Street
R. W. Farnsworth, M.D. (1963) ——— Janesville
305 Court Street
A. R. Curreri, M.D. (1964) ——— Madison
1300 University Avenue
P. T. Bland, M.D. (1965) ——— Westby
107 North Main Street
G. E. Collentine, Jr., M.D. (1966) ——— Milwaukee
2266 North Prospect Avenue
R. S. Baldwin, M.D. ——— Marshfield
650 South Central Avenue
John S. Hirschboeck, M.D. ——— Milwaukee
561 North Fifteenth Street

* * *

ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Chairman of the Council, Chairman
Immediate Past President
President
President-elect
Secretary

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

R. S. Gearhart, M. D.
Chairman

R. S. Gearhart, M.D. (1962) ——— Madison
Chairman 621 South Park Street
C. J. Picard, M.D. (1964) ——— Superior
425–21st Avenue, East
G. B. Murphy, Jr., M.D. (1964) ——— La Crosse
1836 South Avenue
Edgar End, M.D. (1964) ——— Wauwatosa
7608 West State Street
T. H. McDonell, M.D. (1962) ——— Waukesha
217 Wisconsin Avenue
S. L. Henke, M.D. (1963) ——— Eau Claire
314 Grand Avenue
T. E. Boston, M.D. (1963) ——— Hillsboro
840 Water Avenue
H. G. Bayley, M.D. (1963) ——— Beaver Dam
116 Iroquois Parkway
M. V. Overman, M.D. (1962) ——— Neillsville
Neillsville Clinic
John S. Hirschboeck, M.D., Dean, Marquette University School of Medicine ——— Milwaukee
Ex officio 561 North Fifteenth Street

* * *

COUNCIL COMMITTEES

Appointments to the following committees are made by the chairman of the Council at the time of the Annual Meeting in May.

Committees of the Council (composed of members of Council):

Economic Medicine
Executive
Finance
Planning
Scientific Medicine

Council Committees:

Clinical Medicine
Disaster Medical Care
Commission on Medical Care Plans
Commission on State Departments
Editorial Board
Military Medical Service
Health Economics of American Life (HEAL)

OFFICERS OF SECTIONS OF THE STATE MEDICAL SOCIETY

Section on General Practice

President (WAGP) — Albert Stahmer, Wausau
Secretary (WAGP) — J. A. Kelble, Milwaukee
Delegate — R. R. Richards, Eau Claire
Alternate — J. A. Kelble, Milwaukee

Section on Internal Medicine

Chairman — W. K. Simmons, Rhinelander
Delegate — L. J. Kurten, Racine
Alternate — R. L. Gilbert, La Crosse

Section on Neurology and Psychiatry

President (WPA) — Harold N. Lubing, Madison
Secretary (WPA) — Keith Keane, Appleton
Delegate — Lloyd F. Jenk, Milwaukee
Alternate — James R. Hurley, Milwaukee

Section on Obstetrics and Gynecology

President — A. A. Cantwell, Shawano
Vice-President — Elizabeth A. Steffen, Racine
Secretary-treasurer — J. J. Boersma, Green Bay
Board of Governors — R. E. Campbell, Madison
G. S. Kilkenny, Milwaukee
R. F. Lewis, Marshfield
William Luetke, Madison
D. J. Werner, Milwaukee
J. J. Boersma, Green Bay

Section on Ophthalmology and Otolaryngology

Chairman — Howard High, Milwaukee
Secretary — J. W. Doolittle, Madison
Delegate — R. T. Schmidt, Green Bay
Alternate — Frank Treskow, Milwaukee

Section on Orthopedics

President — James E. Miller, Madison
Secretary-treasurer — Arch E. Cowle, Madison
Delegate — P. K. Odland, Janesville
Alternate — M. W. Nelson, Racine

Section on Pathology

President — F. Glassy, Marshfield
Vice-President — D. J. Carlson, Milwaukee
Secretary — R. S. Haukohl, Milwaukee
Treasurer — C. P. Erwin, Milwaukee
Delegate — J. L. Teresi, Milwaukee
Alternate — Lars Kleppe, Beloit
Board of Censors — R. J. Fink, Eau Claire, Chairman
P. G. Piper, Madison
E. A. Brucker, Jr., Madison

Section on Pediatrics

Chairman — E. Pawsat, Marshfield
Delegate — J. P. Conway, Milwaukee

Section on Public Health

President — Margaret E. Hatfield, Kenosha
President-Elect — J. A. Van Sustcren, Sparta
Secretary-treasurer — Rex E. Graber, Chippewa Falls
Delegate — Elmer E. Bertolaet, West Allis
Alternate — George M. Shinners, Green Bay
Executive Committee — Those named above

Section on Radiology

Chairman — B. W. Byrne, Milwaukee
Secretary-treasurer — C. E. Schmidt, Milwaukee
Delegate — Howard Mauthe, Fond du Lac
Alternate — Leslie Jones, Racine

Section on Surgery

Chairman — Jack A. Killins, Green Bay
Secretary — Norman O. Becker, Fond du Lac
Delegate — John T. Mendenhall, Madison
Alternate — Roy B. Larsen, Wausau

Section on Urology

President — J. W. Sargent, Milwaukee
President-Elect — John P. McCann, La Crosse
Secretary — J. T. Hotter, Milwaukee
Delegate — J. W. Sargent, Milwaukee
Alternate — R. S. Irwin, Milwaukee

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, M.D.†	1930
Cornelius A. Harper, M.D.†	1930
John J. McGovern, M.D.†	1931
Louis M. Jermain, M.D.†	1931
Edward Evans, M.D.†	1931
Mina B. Glasier, M.D.†	1932
Arthur W. Rogers, M.D.†	1934
Rock Sleyster, M.D.†	1934
Olin West, M.D.†	1934
Edward A. Birge, Ph. D.**†	1935
Arthur J. Patek, M.D.†	1935
Joseph F. Smith, M.D.†	1937
Eben J. Carey, M.D.†	1938
William S. Middleton, M.D.	1938
Fred G. Johnson, M.D.†	1939
William D. Stovall, M.D.	1940
Ludvig Hektoen, M.D.***†	1941
Stephen E. Gavin, M.D.†	1944
F. Gregory Connell, M.D.	1947
E. R. Schmidt, M.D.†	1949
Armand J. Quick, M.D.	1950
F. A. Stratton, M.D.†	1951
Gunnar Gundersen, M.D.	1953
W. J. Meek, Ph.D.	1953
R. G. Arveson, M.D.†	1957
Edwin B. Fred, Ph.D.	1958
Harry Beckman, M.D.	1959
Elizabeth Comstock, M.D.	1961

** Then president of the University of Wisconsin and professor of zoology.
*** Centennial Award.
† Deceased.

Past Presidents of the State Medical Society

Mason C. Darling, Fond du Lac——1841–1847
J. B. Dousman, Milwaukee——1848, 1849
A. L. Castleman, Delafield——1850, 1851
Harmon Van Dusen, Mineral Point——1852, 1853, 1854
A. L. Castleman, Delafield——1855
John Mitchell, Janesville——1856
D. Cooper Ayres, Green Bay——1857
Clark G. Pease, Janesville——1858, 1859
E. S. Carr, Madison——1860, 1861
Solomon Blood, Rochester——1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, Mineral Point——1867, 1868, 1869
Solon Marks, Milwaukee——1870
H. P. Strong, Beloit——1871
John Favill, Madison——1872
Harmon Van Dusen, Mineral Point——1873
M. Waterhouse, Portage——1874
J. T. Reeve, Appleton——1875
J. B. Whiting, Janesville——1876
J. K. Bartlett, Milwaukee——1877
Darius Mason, Prairie du Chien——1878
Nicholas Senn, Milwaukee——1879
J. G. Meachem, Sr., Racine——1880
Ira Manley, Jr., Markesan——1881
William Meacher, Portage——1882
T. P. Russell, Oshkosh——1883
N. M. Dodson, Berlin——1884
E. W. Bartlett, Milwaukee——1885
G. M. Steele, Oshkosh——1886
S. C. Johnson, Hudson——1887
L. G. Armstrong, Boscobel——1888
J. R. Barnett, Neenah——1889
E. M. Rogers, Hartford——1890
G. D. Ladd, Milwaukee——1891
G. F. Witter, Grand Rapids, Mich.——1892
B. T. Phillips, Menominee, Mich.——1893
B. C. Brett, Green Bay——1894
Almon Clarke, Sheboygan——1895
F. W. Epley, New Richmond——1896
B. O. Reynolds, Lake Geneva——1897
William Mackie, Milwaukee——1898
Herman Reineking, Milwaukee——1899
W. T. Sarles, Sparta——1900
J. F. Pritchard, Manitowoc——1901
W. H. Neilson, Milwaukee——1902
J. V. R. Lyman, Eau Claire——1903
F. E. Walbridge, Milwaukee——1904
C. W. Oviatt, Oshkosh——1905
J. R. Currens, Two Rivers——1906
L. H. Pelton, Waupaca——1907
W. E. Ground, Superior——1908
Gilbert E. Seaman, Madison——1909
Edward Evans, La Crosse——1910
Byron M. Caples, Waukesha——1911
John M. Dodd, Ashland——1912
Arthur J. Patek, Milwaukee——1913
Charles S. Sheldon, Madison——1914
T. J. Redelings, San Diego, Cal.——1915
L. J. Jermain, Milwaukee——1916
Hoyt E. Dearholt, Milwaukee——1917
Gustave Windesheim, Kenosha——1918
D. J. Hayes, Milwaukee——1919
C. R. Bardeen, Madison——1920
H. W. Abraham, Appleton*——1921
M. A. McGarty, La Crosse——1921
S. Hall, Ripon——1922
F. G. Connell, Oshkosh——1923
Rock Sleyster, Wauwatosa——1924
Wilson Cunningham, Platteville——1925
Joseph F. Smith, Wausau——1926
Arthur W. Rogers, Oconomowoc——1927
John J. McGovern, Milwaukee——1928
Karl W. Doege, Marshfield——1929
F. J. Gaenslen, Milwaukee——1930
A. J. McDowell, Soldiers Grove**——1931
C. A. Harper, Madison——1931
Otho Fiedler, Sheboygan——1932
Reginald H. Jackson, Madison——1933
Stanley J. Seeger, Texarkana, Texas——1934
T. J. O'Leary, Superior——1935
R. M. Carter, Green Bay——1936
Stephen E. Gavin, Fond du Lac——1937
James C. Sargent, Milwaukee——1938
A. E. Rector, Appleton——1939
R. G. Arveson, Frederic——1940
R. P. Sproule, Milwaukee——1941
Gunnar Gundersen, La Crosse——1942
F. E. Butler, Menomonie——1943
R. M. Kurten, Racine——1944
Charles Fidler, Milwaukee——1945
P. R. Minahan, Green Bay——1946
C. A. Dawson, River Falls——1947
W. D. Stovall, Madison——1948
K. H. Doege, Marshfield——1949
J. W. Truitt, Milwaukee——1950
H. H. Christofferson, Colby——1951
A. H. Heidner, West Bend——1952
J. C. Griffith, Milwaukee——1953
H. Kent Tenney, Madison——1954
Arthur J. McCarey, Green Bay***——1955
Ervin L. Bernhart, Milwaukee——1956
L. O. Simenstad, Osceola——1957
Harry E. Kasten, Beloit——1958
Jerome W. Fons, Milwaukee****——1958
W. B. Hildebrand, Menasha——1960
E. D. Sorenson, Elkhorn——1961

* Died during term of office as president-elect.
** Resigned, because of health, prior to taking office.
*** Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.
**** Resigned during term of office.

The State Medical Society of Wisconsin

ORGANIZED 1841

L. H. LOKVAM, Kenosha, President
N. A. HILL, Madison, President-elect
R. E. CALLAN, Milwaukee, Speaker

H. W. CAREY, Lancaster, Vice-Speaker
F. L. WESTON, Madison, Treasurer
MR. C. H. CROWNHART, Madison, Secretary

Councilors

J. C. FOX, La Crosse, Chairman — J. M. BELL, Marinette, Vice-chairman

Term Expires 1963

First District:
W. D. James.....Oconomowoc

Second District:
G. J. Schulz.....Union Grove

Term Expires 1964

Third District:
E. J. Nordby.....Madison

Term Expires 1963

J. H. Houghton.....Wisconsin Dells

Term Expires 1964

Fourth District:
E. M. Dessloch.....Prairie du Chien

Term Expires 1964

Fifth District:
P. B. Blanchard.....Cedarburg

Sixth District:
H. J. Kief.....Fond du Lac

Term Expires 1962

Seventh District:
J. C. Fox.....La Crosse
(Chairman)

Eighth District:
J. M. Bell.....Marinette
(Vice-chairman)

Ninth District:
R. W. Mason.....Marshfield

Tenth District:
R. C. Frank.....Eau Claire

Term Expires 1963

Eleventh District:
V. E. Ekblad.....Superior

Twelfth District:
L. J. Van Hecke.....Milwaukee
W. J. Houghton.....Milwaukee

Term Expires 1964

D. M. Willson.....Milwaukee

Term Expires 1962

W. J. Egan.....Milwaukee

Thirteenth District:
W. P. Curran.....Antigo

Term Expires 1962

E. D. Sorenson.....Elkhorn
(Past President)

Delegates to American Medical Association

(Terms end on December 31 of year indicated)

L. O. Simenstad, Osceola, 1962
E. L. Bernhart, Milwaukee, 1962
R. E. Galasinski, Milwaukee, 1963
A. A. Quisling, Madison, 1963

Alternates

John M. Bell, Marinette, 1962
J. M. Sullivan, Milwaukee, 1962
George Collentine, Jr., Milwaukee, 1963
W. B. Hildebrand, Menasha, 1963

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List of Officers and Scheduled Meetings of County Medical Societies

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Ashland–Bayfield–Iron	H. V. Sandin 220 Seventh W., Ashland	C. A. Grand 206–6th Ave., W., Ashland	
Barron–Washburn–Sawyer–Burnett	L. A. Kristensen 24 W. Marshall, Rice Lake	Duane Flogstad Shell Lake	Second Tuesday 7:30 p.m.
Brown	R. L. Troup 123 N. Military Ave., Green Bay	Frank Urban Rm. 308, City Hall, Green Bay	Second Thursday°
Calumet	J. W. Knauf Chilton		
Chippewa	D. A. Sallis Boyd	G. Shonat 100½ Bridge, Chippewa Falls	Second Tuesday
Clark	Sarah Rosekrans 304 Hewett St., Neillsville	K. F. Manz Neillsville	
Columbia–Marquette–Adams	Fred Gissal Dells Clinic, Wisconsin Dells	H. L. Conley 414 Broadway, Wisconsin Dells	Every Third Month 7:00 p.m.
Crawford	M. S. Garrity 610 East Taylor St., Prairie du Chien	H. L. Shapiro Prairie du Chien	Third Wednesday
Dane	C. W. Stoops 110 E. Main, Madison	D. A. Peterson 110 E. Main, Madison	Second Tuesday Sept. through June
Dodge	Robert Boock 119½ Front St., Beaver Dam	E. R. Taake 105 N. Lincoln, Beaver Dam	Last Thursday°
Door–Kewaunee	C. W. Stiehl Algoma	W. S. Hobson 25 S. Madison, Sturgeon Bay	
Douglas	I. H. Lavine 216 Board of Trade Bldg., Superior	John Foderick 324 Board of Trade Bldg. Superior	First Wednesday°° Hotel Superior
Eau Claire–Dunn–Pepin	A. W. Hilker 314 Grand Ave., Eau Claire	G. C. Giffen 116 West Grand Ave. Eau Claire	Last Monday
Fond du Lac	D. W. McCormick 55 N. Portland St., Fond du Lac	W. G. Kendall 92 E. Division St., Fond du Lac	Fourth Thursday°
Forest	O. S. Tenley Wabeno	D. V. Moffet Crandon	
Grant	Cedric S. King Cuba City	H. W. Carey Lancaster	Last Thursday, March, June, Sept. and Nov.
Green	P. Marty New Glarus	Wm. J. Staab, Jr. 921 16th Ave., Monroe	
Green Lake–Waushara	R. A. Kjentvet Wild Rose	Roy Hong Wild Rose	Last Thursday, every other month starting in Jan.

° Except June, July and August.

°° Except July and August.

(Continued on next page)

List of Officers and Scheduled Meetings of County Medical Societies *(Continued)*

COUNTY	PRESIDENT	SECRETARY	MEETING DATE
Iowa	N. G. Rasmussen 109 W. Fountain St. Dodgeville	E. J. Hohler Mineral Point	First Thursday following first Monday
Jefferson	Stephen Ambrose 216 Center St., Whitewater	John H. Becker 115 N. Third, Watertown	Third Thursday*
Juneau	V. M. Griffin Hess Clinic Mauston	M. S. Tverberg Mauston	Second Tuesday Hess Clinic in Mauston
Kenosha	Harold Kappus 6223 22nd Avenue, Kenosha	Frank Williams, Jr. 6334 8th Ave., Kenosha F. John Shannon, Ph.D., Exec. Secy. 416–75rd Street, Kenosha	First Thursday* Elks Club
La Crosse	Karl Ruppenthal Bangor	Geo. B. Murphy, Jr. 1836 South Ave., La Crosse	Third Monday
Lafayette	N. A. McGreane Darlington	L. L. Olson Darlington	Last Tuesday
Langlade	R. W. Cromer 824½ Filth, Antigo	John McKenna 1125 Superior, Antigo	First Monday
Lincoln	Edward Jarvis Tomahawk	E. O. Ravn, Jr. 1802 9th St., Merrill	
Manitowoc	R. G. Yost 918 Washington St. Manitowoc	R. G Strong 821 Washington St. Manitowoc	Last Thursday
Marathon	O. R. Kelley 803 3rd St., Wausau	G. J. Baehhuber 614 N. 3rd Ave., Wausau	
Marinette–Florence	Clark Boren 1510 Main St., Marinette	K. G. Pinegar 516 Houston, Marinette	Third Wednesday St. Joseph's Hospital
Milwaukee	Roman E. Galasinski 3333 S. 27 St., Milwaukee	Francis F. Rosenbaum 425 E. Wis. Ave., Milwaukee Mr. J. O. Kelley, Ex. Sec. 756 N. Milwaukee, Milwaukee	Second Thursday
Monroe	C. E. Kozarek Tomah	J. S. Mubarak Tomah	Third Monday
Oconto	H. A. Aageson 1113 Main St., Oconto	F. W. Klutzow Gillett	
Oneida–Vilas	F. A. Cline 123 N. Stevens Rhinelander	W. K. Simmons 1020 Kabel, Rhinelander	Monthly
Outagamie	J. N. Bonner 401 N. Oneida St., Appleton	J. G. Anderson Irving Zuelke Bldg., Appleton	Third Thursday* Elks Club
Ozaukee	R. H. Dorr Belgium	R. F. Henkle 549 W. Grand, Pt. Washington	
Pierce–St. Croix	C. F. McCusker Glenwood City	P. H. Gutzler River Falls	Third Tuesday
Polk	O. N. Arneson Amery Clinic, Amery	M. G. Marra Amery	Third Thursday 7:00 p.m.
Portage	Austin Dunn 538 Main St., Stevens Point	Albert Kohn 313 N. Fremont, Stevens Point	
Price–Taylor	Walter E. Niebauer Phillips	John J. Rens Phillips	Last Saturday, Feb., May, Aug., and Nov.
Racine	Frank M. Hilpert 312 7th St., Racine	Frank J. Scheible 632 High St., Racine Mr. G. N. Geraghty 600 Villa Street, Racine Exec. Sec.	Third Thursday
Richland	J. I. Spear 139 Main St., Richland Center	L. M. Pippin Richland Center	First Thursday Richland Hospital
Rock	Eugene Betlach Mercy Hospital, Janesville	W. A. Scholten 1146 Grant, Beloit	Fourth Tuesday
Rusk	M. L. Whalen Bruce	H. F. Pagel Ladysmith	First Tuesday
Sauk	J. T. Siebert Baraboo	R. G. Knight Reedsburg	Second Tuesday*
Shawano	H. C. Marsh 137½ S. Main, Shawano	A. J. Sebesta Shawano	Third Wednesday
Sheboygan	Willard G. Huibregtse 1011 N 8th St., Sheboygan	J. F. Kovacic 708 St. Claire Ave. Sheboygan	First Thursday
Trempealeau–Jackson–Buffalo	Rolland Thurow 221 Main St., Black River Falls	J. H. Noble 1109 Harrison Black River Falls	Fourth Tuesday
Vernon	DeVern Vig 122½ S. Main St., Viroqua	W. N. Otterson Westby	Last Wednesday
Walworth	Kenneth C. Bill 104 S. Wisconsin, Elkhorn	R. J. Rogers Elkhorn	Second Thursday*
Washington	J. F. Baumgartner 1347 Evergreen St., West Bend	R. F. Sorensen 139 S. 6th Ave. West Bend	Fourth Thursday
Waukesha	T. H. McDonell 217 Wisconsin Ave., Waukesha	W. E. Rosenkranz 726 N. Rochester, Mukwonago	First Wednesday
Waupaca	Sam Salan 105 Jefferson St., Waupaca	H. S. Caskey Clintonville	
Winnebago	Charles Behnke 421 Jefferson St., Oshkosh	D. J. Ryan 117 N. Commercial, Neenah	First Thursday
Wood	G. G. Schields P. O. 270, Wisconsin Rapids	John W. Rupel 512 Cypress St., Marshfield	Four times a year

* Except June, July and August.

Officers of State Boards and Commissions

Wisconsin State Board of Health

MEMBERS OF THE BOARD

Carl N. Neupert, M.D., M.S.P.H.—Madison
Secretary
William T. Clark, M.D. (1963)—Janesville
President
Joseph C. Griffith, M.D. (1962)—Milwaukee
Vice-president
Elizabeth Baldwin, M.D. (1964)—Marshfield
John S. Hollingsworth, D.D.S. (1965)—Sheboygan
Edward N. Vig, M.D. (1966)—Viroqua
Jacob E. Kaufman, M.D. (1967)—Green Bay
Irving J. Ansfield, D.O. (1968)—Milwaukee

State Health Officer—Carl N. Neupert, M. D., M. S. P. H.
Assistant State Health Officer—E. H. Jorris, M. D., M. S. P. H.

GENERAL ADMINISTRATION

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SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

The sale of contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used, is prohibited by Section 151.15 of the Wisconsin Statutes to all persons other than a physician or pharmacist duly licensed in this state. In no event may such article, drug, or preparation be sold to any unmarried person.

Prohibited also is the advertising or displaying of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Wisconsin Statutes, 1959, Section 151.15.

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PRESIDENT'S PAGE

Unity In Diversity

AS DROPLETS OF water come together to form even larger pools, so in this day and age groups such as business, industry, labor and political philosophies flow together to merge and consolidate to strengthen their position. At the same time a paradoxical situation has developed in the "organized" medical profession. Never have we had such excellent and widespread organizational structure statewide and national in scope. But at the same time never have we had so many points of friction and head-on collisions in both areas. This has been aided and abetted by the fragmentation of the medical profession which in turn has come about by the emerging differences in our approach to socio-economic changes and our attitude toward the supplying of medical services under varying insurance, closed panel and governmental plans. This can be a healthy and democratic process but only if short of hari-kari.

Another development giving impetus to this fragmentation is the inordinate growth and multiplicity of specialty and subspecialty groups until they no longer can be referred to as fragments, but rather as splinters.

Many of these minuscule groups appear very formidable on their letterheads with resounding organizational names, suggesting titles such as "The American College of Meckle's Diverticulum Surgeons," "The American Academy of Subungual Patho-Dermatologists," and "The American Society of Trichomonas Vaginalists."

Thus, from his new found Olympian heights of limited special interest the charter member can look about him and say in the grand manner we have heard so often, "I am not particularly interested in the problem because my practice is limited to the splenic flexure of the colon!", or "Why should I be concerned about the issue? After all I am a member of the Academy of _____ (you name it).

What a mouthful these self-serving organizations make in the saying, and what a delight for the press, competent in so many ways, but so hungry for any morsel of scientific or pseudoscientific news to try to satisfy the ever-increasing public appetite that it fails to distinguish between fact and fiction.

But this is not the greatest evil. These splinter groups tend to separate the physician from his fellows and patients and remove him from his rightful position in the mainstream of medicine concerned with matters of public health and interest in depth. It separates the physician from his proper concern for man as a whole and his environmental relationship.

When the individual permits a subgroup of the house of medicine by whatever name to absorb all of his strength and energy and create the atmosphere that he stands aloof from the universal problems confronting man's health in society, he is indeed in error. For as man does not live by bread alone, the true physician, in addition to his special interest, cannot free himself from the whole man and his problem in depth and breadth. Vision that is microscopic in perspective and myopic in depth cannot and will not satisfy the public right and medical responsibility.

To reach this goal of our proper relationship to the whole man, the generally recognized major specialty groups should confine their efforts to the unusual, the complicated, and preferably the referred problem after it has been evaluated by one such as a generalist or internist with wider visual fields.

Is it rational that a highly trained pediatrician should run through a large number of infants in a well baby clinic that could be done equally as well by the competent family physician? And is this a specialized service that justifies a relatively higher fee? The same reasoning can be applied to the so-called

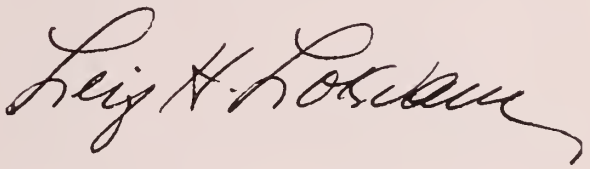
thorough evaluation of each and every patient who presents himself, with all the ornaments of multiple laboratory procedure and irrelevant tests regardless of the nature of his complaint or the effect on his purse. To project this reasoning further, one is justified in inquiring whether a surgical procedure such as a routine D & C or incision and drainage of a superficial abscess, that could be performed equally well by many, justifies the payment of a specialist fee.

The generalist should not invade those areas of medical practice where his training and experience are limited. He should freely and willingly seek consultation in those areas to better serve his patients.

Further, the public should be informed that it would be wiser and more economical to heed the counsel of their medical adviser before departing post-haste to Timbuktu for their super specialized care that in many instances is not required or if indicated is available in his own community. Finally, the public should be told that much of the increased cost of medical and especially hospital services is due in large part to its rapacious appetite for more and more so-called "tests" and ever-increasing hospitalization for the most trivial of ailments. Much of this could be avoided if the patient and physician demonstrated increasing confidence in and loyalty to each other.

Human nature being what it is and always has been, one is tempted at times to paraphrase the philosopher and join with him when he cried out in despair: "If all the world were emptied of all but the generalist and specialist, the generalist would quarrel with the specialist and the specialist would quarrel with the generalist."

We should look at these problems as though viewing them through the eyes of a child and seeing them for the first time. Prejudice must be cast aside. We must regroup our forces and fuse our fragments for better medical service through unity in diversity. Our divergent forces may then flow together in a tidal wave of strength and purpose for the ultimate good of the sick, which is our ultimate goal.



MUSINGS OF A DRUG MANUFACTURER

DESPITE ALL THE seeming inefficiencies of free competition, I would rather be deluged with more medicinal preparations than I know how to use than be forced to sit idle at the bedside of a patient doing nothing because there are not enough drugs to save lives or, at the very least, to bring comfort to my patients. I would rather be accused of trying too hard to market my useful products than to default on marketing and, thus, to lose sales and thereby increase costs. I would rather be stacked up over an airfield for two hours in a 1961 jet than to have the sky all to myself in something like the Wright Brothers' original flying machine. I prefer to suffer the pangs of perplexity in having countless alternatives in the purchase of a new car than to have no choice at all.—THEODORE G. KLUMPP, M.D., president, Winthrop Laboratories, in *New York Medicine.*

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Physician Responsibility

WHEN AN INDUSTRIALIST with the stature of R. Conrad Cooper of the United States Steel Corporation speaks on the subject of health cost control, it behooves every physician to study his message with utmost care.

In an address before the last annual meeting of the American Academy of General Practice, Mr. Cooper outlined with remarkable clarity the problem facing industry. The suggested direction of the solution must be accepted enthusiastically by the medical profession to prove its capacity to behave responsibly in a free society.

As excerpted in the November, 1961, issue of *Health Insurance Viewpoints*, a publication of the Health Insurance Council, here is Mr. Cooper's statement:

". . . By way of preface, I will state three basic beliefs.

"First, the management people I represent believe implicitly in the competitive, free enterprise system. We believe that the private practice of medicine is, and should be, a part of that system.

"Secondly, we favor freedom of the individual; freedom to choose where he wants to live, where he wants to work and what kind of work, and freedom to spend or save his earnings in the way he wants. We include in this, freedom of the individual to choose his own source of medical attention, physician, clinic, or whatever medical agency he wishes. We do not feel that someone else should make the choice for him.

"Third, we feel strongly that freedom and responsibility for one's self and one's actions must go hand in hand. Having someone else bear the full cost of medical care for one's self and his family tends inevitably to erode personal responsibility. Moreover, it would seem bound to result in a tremendous and unwarranted increase in the total cost of such service. . . .

". . . We recognize that there is a direct relation between health and an individual's effectiveness at work. Therefore, any improvement in the quality or availability of medical care for our people would be of direct concern to us, even if just as a matter of good business. Beyond that, I have yet to meet the management man who isn't interested in the physical well-being of his co-workers as a matter of human interest.

"Our second concern is that we find ourselves involved, perhaps unwittingly, certainly unwillingly, in the middle of a growing conflict regarding structure of the medical care system that exists in America today. Unhappily there are signs that some people wish to make collective bargaining a major area for the pursuit of this conflict. This is especially regrettable because we believe that if restructuring of the system is needed, and is soundly to come about, the way must be led by the medical care practitioners, and not by labor unions, industry, government, or anyone else.

"Our third concern about medical care runs to its costs which are steadily and steeply rising with no end yet in sight. In my own company insured medical care costs, including cost of sickness and accident benefits, amounted to about 40 million dollars in 1960.

"These matters of medical care structure, quality, and costs are extremely important to all of us.

"Medical care in this country is a very complex fabric that has produced the highest quality of such service in the world. This has been brought about by those in the medical profession performing in consonance with the free enterprise system.

"All of us, of course, favor continued improvement in the quality of service. And I believe it is clear that costs must be controlled or reduced.

"To the extent that we of management must be involved in the growing conflict regarding structure of the service, we will be guided by the beliefs that:

1. Leadership for change, if such is to be made constructively, must come from those in the medical care profession.

2. Those who would change the structure should beware lest they be tinkering with complexities that might: damage the quality and progress of medical care; reduce costs at the expense of quality; erode the freedom and self-determination of the individual by restricting his choice of doctor or type of service; or weaken the responsibility of the individual so as to waste services and increase costs.

"As you know, many people other than industrial management, are also concerned about the continuing rise in the cost of medical care.

"The major element contributing to the rise in costs has been in hospital expense. Part of this rise has been due to increased employment costs for hospitals; part is due to advance in medical knowledge which requires newer diagnostic and treatment facilities. But part is also due to the rate of utilization of hospital facilities and services and of medical and surgical procedures.

"And unfortunately there appear to be some physicians who do not recognize their role in this. Costs due to medical advances are all to the good; and costs due to rising capital and operating expenses may be beyond the physician's control. But it is the physician who makes the decision as to who is hospitalized, when and for how long, what hospital services will be used, when the patient is discharged, whether surgery will be performed, whether and for how long a man stays out on sickness disability benefits, etc. All of these are determinants in the total expenditures for illness.

"As businessmen, we know of no way to meet our competitive challenges except to improve the efficiencies of our operations, reduce the costs of production, and increase the quality and quantity of our products and services.

"We believe that . . . the medical profession likewise faces a major and comparable competitive challenge. It has been said that the rise in costs will continue until the only one able to pay for it will be Uncle Sam, and then we will have socialized medicine. If costs continue to rise without end, this could happen. We in industry do not want socialized medicine, any more than we want socialized industry.

"We believe that an approach to the control of costs should first be the responsibility of the physicians who are the core of the system and know it intimately.

"We are heartened, too, by many evidences that the medical profession itself is developing concerted efforts to meet this challenge. The San Joaquin Valley Medical Society plan, the "Marshall Plan" of the Medical Society of Western Pennsylvania, the new Commission on the Cost of Medical Care of the American Medical Association, and many other such modes of attention to the problem by physician groups show that doctors are themselves taking steps to meet the problem.

"We applaud such steps and urge all physicians to devote themselves to its solution."

—D. N. G.

Nuclear Morality

THE MORAL PROBLEMS that presented themselves to the world with the first mushrooming of the nuclear age were clearly open to solution by existing principles of guidance. Now that the decision on whether to use nuclear weapons is no longer ours to make, the moral problems of nuclear defense point down a long dark corridor in which the ethical lights of our culture throw confusing shadows and reflections of questionable forms.

To protect our population in a nuclear war, which we hope never comes, the Civilian Defense Agency has distributed instructions for the preparation of individual bomb shelters. It encourages each family head to look to his family's own survival. Those unfortunates in target areas who live in apartment buildings, hotels, or other multiple-type dwellings are left to whatever the community may be inclined or able to afford.

The proposition of individual bomb shelters has already provided a sample of the new moral problems of the nuclear age—an age of total destruction. What do the sheltered do about the less fortunate family who demands admittance at the last minute? Is, as one clergyman suggests, a shotgun a necessary article of the shelter's equipment for survival? Are doctors, pharmacists, plumbers, electricians, technologists, and other personnel vital to community welfare, entitled to shut themselves up in their own shelters, thus effectively removing them from the possibility of community service? What of the matter of selection for survival? Is a greybeard with a long record of service to mankind entitled to a place in a shelter from which a child may be evicted to be irradiated to a crisp? Can we afford the impartiality of chance in a situation that calls for the mustering of the community's finest talent? On what basis can we select the survivors in a bombed-out world? If there is a possibility of reconstruction after the holocaust, mankind must be prepared for it. But who is so charismatic as to assume the immense burden of even beginning the preparation?

Some of us may be able to find answers to these new problems in the familiar tenets of our religion or in traditional subscriptions of philosophy. Others may find such guidance more of a hindrance than a help. Certainly, the inevitable conflict of moral systems will contribute to the confusion of these parlous times. As we enter the darkening gloom of a new age, fraught with the terror of a strangely errant technology, we no longer have signposts deepset in the high walls of our cultural heritage as reference points for our behavior. We no longer can look to history for wisdom, inspiration or precept. There has never been in all of human history anything like what the human race is facing now.

The moral perplexities in which doctors may become involved will undoubtedly be greater than those of the rest of the population. For as citizens of a warring nation, ours will be the responsibilities of all loyal patriots. In addition, since we are so closely involved in the preservation of life, we must face awful decisions in medical situations hardly to be imagined now. We know enough about the effects of intense radiation to be able to limn some of the choices fateful for the human race that may face us. Will our present structure of medical ethics serve us then? Will we be able to perform our function in circumstances where all the words that have been said, where all the moral ideas that have graced the intellect of man no longer have relevance?

Perhaps we will never come to nuclear immolation. Perhaps common sense or self-interest or moral responsibility will prevail, and we will escape the doom of all that we hold precious. A formula for the avoidance of nuclear war is urgently to be sought. But while diplomats maneuver, while the military perfect faster and more effective weapons, the rest of us must prepare for what now seems the end of the old light and the fearsome beginning of a new darkness. We can prepare as best we can for the survival of our bodies and a few of our goods. But most importantly, we must assess our moral values in terms of what we can expect in a totally rearranged world. There should be discussion now of whether we will permit the new world to conform us to its barren landscape or whether we will make the new world a place where the human spirit will again rise and flourish. New moral preparation must proceed with urgency equal to the development of new weapons.

As members of a profession that is sure to be critical in the post-holocaust world, our choice is to be ready to perform by some system of moral values or to return to the primitive behavior of savages.—D.N.G.

MEDICOLEGAL INFORMATION

AVAILABLE

Individual physicians or county medical societies may wish to make use of several informational materials and speakers on topics relating to medical-legal problems of physicians.

FILMS

The following films are available upon request to the State Medical Society of Wisconsin. Please allow at least two weeks advance notice if possible. These films were produced by Wm. S. Merrill Co. under direction of the American Medical Association, American Bar Association and American Hospital Association.

"Medical Witness"—Dramatically illustrates use of medical witness in court, providing do's and don'ts for effective testimony. Black and white, sound, 30 minutes.

"Doctor Defendant"—Suggests how the physician can prevent professional liability suits; shows county medical society grievance committee in action. Black and white, sound, 30 minutes.

"Man Who Didn't Walk"—Legal and medical aspects of personal injury case. Shows lawyers for plaintiff and defendant as they establish evidence from physicians, pretrial conference, and summation to jury. Black and white, sound, 30 minutes.

"A Matter of Fact"—Discusses the need for an adequate medical examiners' system versus the presently common coroners' system. Black and white, sound, 30 minutes.

"No Margin for Error"—Portrays certain aspects of physician-hospital activity bearing upon professional liability. Black and white, sound, 30 minutes.

"Chemical Tests for Intoxication"—Deals with the subject of chemical tests for intoxication and the introduction of the results of such tests in court. Black and white, sound, 30 minutes.

SPEAKERS

County medical societies interested in obtaining speakers on medicolegal subjects may contact the State Medical Society, Box 1109, Madison 1, Wisconsin (phone ALpine 6–3101), or the State Bar Association of Wisconsin, 402 West Wilson Street, Madison, Wisconsin (phone ALpine 7–3838).

LITERATURE

Copies of the following materials are available upon request to the State Medical Society of Wisconsin:

★ Interprofessional Code

★ Medicolegal Consent Forms (see January 1958 Blue Book issue of the *Wisconsin Medical Journal*)

★ Test Your A. Q. (Alcohol Quotient), 20 Questions on alcohol

★ Malpractice and the Physician

★ Medicolegal Aspects of Blood Transfusions

★ Medicolegal Aspects of Blood Grouping

SCHEDULE OF PROGRAMS OF THE "MARCH OF MEDICINE"

"March of Medicine" is in its seventeenth consecutive year of radio broadcasting. The programs, which are tape recorded, feature H. Kent Tenney, M.D., discussing various health problems with a lay person who is called "Your Medical Reporter." At present 52 stations in Wisconsin are cooperating in presenting this program as a public service feature. The most recent schedule is as follows:

Station	*City*	*Day*	*Time*
WATK	Antigo	Saturday	8:45 a.m.
WATW	Ashland	Saturday	11:15 a.m.
*WLBL	Auburndale	Wednesday	9:15 a.m.
WWIS	Black River Falls	Saturday	9:10 a.m
*WHSA	Brule	Wednesday	9:15 a.m.
*WHKW	Chilton	Wednesday	9:15 a.m.
WAXX	Chippewa Falls	Saturday	11:45 a.m.
*WHWC	Colfax	Wednesday	9:15 a.m.
*WHAD	Delafield	Wednesday	9:15 a.m.
WBIZ	Eau Claire	Sunday	6:45 p.m.
WERL	Eagle River	Saturday	9:45 a.m.
KFIZ	Fond du Lac	Thursday	7:15 p.m.
WJPG	Green Bay	Saturday	8:45 a.m.
WTKM	Hartford	Tuesday	4:45 p.m.
WHSM	Hayward	Saturday	10:00 a.m.
*WHHI	Highland	Wednesday	9:15 a.m.
*WHLA	Holmen	Friday	10:30 a.m.
WCLO	Janesville	Tuesday	8:15 p.m.
WLIP	Kenosha	Saturday	9:10 a.m.
WLDY	Ladysmith	Saturday	9:00 a.m.
WHA	Madison	Wednesday	9:00 a.m.
*WHA-AM	Madison	Wednesday	9:00 a.m.
*WHA-FM	Madison	Wednesday	9:00 a.m.
WIBA	Madison	Saturday	11:15 a.m.
WOMT	Manitowoc	Saturday	9:15 a.m.
WMAM	Marinette	Sunday	10:30 p.m.
WDLB	Marshfield	Saturday	9:45 a.m.
WIGM	Medford	Saturday	9:45 a.m.
WEKZ	Monroe	Saturday	1:45 p.m.
WXMT	Merrill	Tuesday	2:15 p.m.
WMNE	Menomonie		
WNAM	Neenah	Sunday	7:05 p.m.
WCCN	Neillsville	Saturday	9:00 a.m.
WPFP	Park Falls	Saturday	10:45 a.m.
WSWW	Platteville	Saturday	11:15 a.m.
WPDR	Portage	Thursday	10:45 a.m.
WIBU	Poynette	Thursday	2:35 p.m.
WWCF-FM	Poynette	Sunday	3:45 p.m.
WPRE	Prairie du Chien	Saturday	10:15 a.m.
WRJN	Racine	Sunday	6:30 p.m.
WRDB	Reedsburg	Saturday	12:45 p.m.
WOBT	Rhinelander	Saturday	10:15 a.m.
WJMC	Rice Lake	Saturday	9:45 a.m.
WCWC	Ripon	Saturday	9:00 a.m.
WTCH	Shawano	Sunday	6:15 p.m.
WDOR	Sturgeon Bay	Tuesday	9:05 a.m.
WQMN	Superior	Saturday	11:15 a.m.
WTMB	Tomah	Wednesday	3:00 p.m.
WTRW	Two Rivers	Wednesday	11:00 a.m.
WISV	Viroqua	Saturday	8:45 a.m.
WTTN	Watertown	Friday	11:30 a.m.
*WHRM	Wausau	Friday	10:30 a.m.
WSAU	Wausau	Saturday	5:15 p.m.
WBKV	West Bend	Saturday	11:15 a.m.

* Radio stations in the state network.

THE MEDICAL FORUM

Opposition To King–Anderson Bills Increases As Issue Nears Possible Action In Congress

Activities Suggested For County Societies

Congress reconvened January 10, with health care for the aged financed under social security as one of the major administration goals of the session.

Thus, the next few months could be crucial in determining the trend of future health care for the nation.

The legislation in question—the King Bill, H. R. 4222, and the Anderson Bill, S. 909.

Hearings were held on the King Bill in July and August by the House Ways and Means Committee. With Congress now reconvened, that committee can vote on the bill at any time. If the majority of the 25 members vote for the bill it will go to the floor of the House of Representatives for action. If passed by the House, it will go to the Senate for action there.

Thus, opponents to the measure must have the support of 220 or more Congressmen and 51 or more Senators if the bill is to be defeated.

Following are ways in which county medical societies can effectively make their views known and encourage opposition to the King–Anderson proposals:

1. Inform each member as to the danger of a compulsory medical care program based on a social security tax.
2. Inform the members of other business, professional and civic organizations in your community along the same lines.
3. Set up the mechanism in your medical society that will encourage each member to write his Congressman.
4. Work with the other organizations in your community to set up similar mechanisms.

Each county society is encouraged to appoint a special committee to inform its members. Activities of such a committee could be:

1. Where possible, arrange for a special meeting of the society on the subject, with representatives of the auxiliary present.
2. Supply each physician's office, and if possible each hospital waiting room, with literature explaining the issues.
3. Arrange with other local groups such as pharmacists, dentists, attorneys, civic clubs, chambers of commerce, and county farm bureaus to distribute literature at their meetings.
4. Contact local news media and discuss the subject of medical care for the aged with them, fully answering any questions they might have.
5. Arrange for medical society funds for purchasing advertising space to explain the issues. Ad mats will be available later for this purpose.

Resolutions from your local medical society, stating why the group is opposed to King–Anderson legislation should be sent to your Congressman, Senators, and Representative Wilbur Mills, chairman of the House Ways and Means Committee.

Individual physicians should write to their Congressman citing reasons for their opposition to the bills, pointing out instances of how the aged are being cared for in their own communities, and urging him to contact members of the House Ways and Means Committee.

Local medical societies should also encourage other groups to pass

(Continued on page 98)

"BLUE BOOK" ISSUE

This issue of the *Wisconsin Medical Journal* contains a variety of articles relating to medicolegal matters of direct concern to the physician in his relationship to governmental agencies. An annual presentation since 1924, the January "Blue Book" edition is unique among medical journals of the United States.

Contained in this year's "Blue Book" are articles on Chapter 484, Laws of Wisconsin, 1959, relating to fee splitting between physicians and others; Chapter 301, Laws of Wisconsin, 1959, relating to inspection of physician and hospital records; use of the title "doctor"; and a host of other important items that concern the physician in his daily practice. Also included is a schedule of "must deadlines", the Constitution and Bylaws, committee structure of the state medical organizations, and a list of Society members.

Each January "Blue Book" issue is an outstanding legal service to members of the Society. A permanent file of these issues for future reference is recommended.

There is a limited number of the 1958 "Blue Book" available from the Society upon request. This issue contained a notable compilation of medical "consent" forms of all types.

Opposition To King–Anderson Bills Increases

(Continued from page 47)

resolutions opposing these bills and forward them to Washington.

Letters from non-medical persons, resolutions from medical auxiliaries, and letters from individual members are important. Members of the auxiliaries can also be influential in encouraging women's organizations in the county to take similar action.

It is important to note that in the interim, between sessions of the Congress, proponents of the bill have been far from silent:

1. The AFL–CIO held, in the fall of 1961, a series of 17 regional meetings throughout the nation on the issue.
2. The McNamara subcommittee is conducting a series of hearings throughout the nation (one in Minneapolis) the principal purpose of which is to get support for King–Anderson legislation.
3. The administration sponsored 12 regional White House Conferences during November, (one in Madison) with financing health care of the aged through social security one of the chief topics.
4. Numerous other nationwide and local efforts are being carried out to gain support for these bills or similar legislation.

CMCP Names Committee On Utilization

The Commission on Medical Care Plans of the State Medical Society has formed a Utilization Committee to review repetitive claims problems and discuss such broad subjects as excess utilization.

Chairman of the new committee is Dr. Paul B. Mason, Sheboygan. Members are Dr. M. D. Davis, Milton; Dr. C. G. Reznichek, Madison; Dr. E. P. Ludwig, Wausau; and Dr. Donald A. Jeffries, Shawano.

MATERIALS AVAILABLE ON

Health Care Of The Aged

The following materials are available to County Medical Societies and individual physicians for use in providing information to the public on health care for the aged.

"Helping Those Who Need Help" _____ Pamphlet
"Medical Aid for the Aged" _____ Pamphlet
"Socialized Medicine and You" _____ Pamphlet
"America—Beware the Welfare State ___ *Reader's Digest* Reprint
"A Simple Error in Logic" _____ *Fortune Magazine* Reprint
"I Quit Socialized Medicine" _____ *Nation's Business* Reprint
"A Family Doctor's Fight Against Socialized Medicine" _____ *Look* Magazine Reprint
Ronald Reagan Records ___ A recorded talk on Socialized Medicine

Testimony of the American Medical Association before the House Ways and Means Committee

Editorial Writers' Kit

Speaker's Kit

Newspaper Ad Mats

These materials may be ordered, free of charge, through the State Medical Society of Wisconsin, 330 East Lakeside Street, Madison, Wisconsin, or from the Field Service Division, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

Plan Wisconsin Study on Medical Care Cost

The Charitable, Educational and Scientific Foundation of the State Medical Society has made a contribution of $10,000 to the Commission on the Cost of Medical Care of the American Medical Association.

The contribution, made possible through a grant provided by Wisconsin Physicians Service, is for pertinent research in Wisconsin.

It was reported at the Denver session of the AMA House of Delegates that the funds will be used for a comparative study of solo and group practice with regard to the financing of medical care.

The Commission on the Cost of Medical Care was authorized by the AMA Board of Trustees in February, 1960, in an effort to determine the factors involved in determining expenditures for and prices of the individual components of medical care.

Wisconsin Spokesmen Before Senate Group On Care of the Aged

Dr. C. A. Olson, Baldwin, represented the State Medical Society of Wisconsin at a U.S. Senate subcommittee hearing on care for the aged held in Minneapolis early in December.

Also appearing before the committee was Mrs. E. M. Dessloch, Prairie du Chien, president-elect of the Woman's Auxiliary to the State Medical Society.

Doctor Olson stated opposition to the King–Anderson bills, which would use the social security mechanism to finance health care for the aged, and spoke in favor of the Kerr–Mills approach. Mrs. Dessloch also opposed the King–Anderson measures, based on her experience as operator of a nursing home in Prairie du Chien.

Doctor Olson appeared on Station WCCO-TV in Minneapolis, expressing his views on the federal legislation.

Division On Safe Transportation Backs Use Of Auto Seat Belts

The Division on Safe Transportation of the Commission on State Departments, meeting December 14 in Madison, outlined promotional plans for the use of automobile seat belts; proposed a study on the operation and equipping of ambulances and training of drivers and personnel; and reaffirmed its support of legislation on "implied consent" for chemical tests for intoxication.

In view of Wisconsin's new law, requiring the installation of seat belts in all 1962 and later model cars sold in the state, the Division turned its attention to encouraging use of the belts.

Following are the projects approved:

1. Distribution of the pamphlet "Seat Belts Save Lives" to all member physicians for use in their waiting rooms.
2. Use of a postage meter cachet on State Medical Society outgoing mail, encouraging purchase and use of seat belts.
3. An exhibit at the annual meeting on seat belts.
4. Placing of a seat belt exhibit in the State Capitol in cooperation with the State Board of Health.

Concerning ambulances, Dr. Richard B. **Windsor**, Sheboygan, chairman of the Division, expressed the view that statewide improvement in the operation and equipping of the vehicles and training of the drivers and attendants is needed.

The Division proposed a study of the situation, with the intent of developing a guide for use at the local level in upgrading ambulance service.

Dr. James L. **Weygandt**, Sheboygan Falls, urged reaffirmation of the Division's opinion that a law on "implied consent" for chemical tests for intoxication is desirable in Wisconsin. A bill to that effect was killed in the 1961 session of the Legislature.

Some states now have such laws, stating that a person, in obtaining a license to operate a motor vehicle, gives his implied consent to submit to tests for intoxication.

Under present Wisconsin law, according to legal counsel for the State Medical Society, consent is required before taking a blood sample for the purpose of determining alcohol content in cases of alleged drunkenness. By doing otherwise, in its opinion, the physician may open up the possibility of suit for assault and battery.

AMA Urges Continued Recruitment Activities

State and county medical societies were urged to continue and expand their recruitment activities designed to interest qualified young people in medical careers in a resolution approved by the AMA House of Delegates at its November meeting.

Particular emphasis was placed on establishment of Future Physicians' Clubs and Medical Explorer Posts. Information on how to establish such organizations can be obtained from the AMA Council on Medical Education and Hospitals.

MILWAUKEE SOCIETY HELPS SCOUTS STUDY CAREERS IN MEDICINE

An Explorer Scout Medical Specialty post program, in which high school age boys will explore a future in medicine, has been organized by The Medical Society of Milwaukee County.

Students from six Milwaukee high schools will be given the opportunity to acquaint themselves with the practice of medicine and a medical career through the program. Additional posts in other schools are expected to be established in the near future.

Guiding the activities are Drs. Frederick **Bunkfeldt**, Jr., John O. **Chamberlain**, John W. **Kearns**, Brian C. **McLaughlin** and Gerald L. **Mullaney**. Dr. Richard O. **Mossey**, who launched a similar program in Wauwatosa last fall, will act as institutional representative of the medical society and Dr. Robert B. **Pittelkow** will be the advisor.

CES Foundation Named To Administer Racine County Fund

The Racine County Medical Auxiliary has transferred its Beverly Schuster Memorial Fund to the Charitable, Educational and Scientific Foundation of the State Medical Society.

The fund, used for making loans to young women already started upon or commencing a career in nursing or paramedical career, amounts to $1,235.17.

The Racine auxiliary will retain the right to determine eligibility for loans, which will probably be limited to young women from Racine County.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

Is your disability income insurance up-to-dote?

To find out, apply these tests:

- Is your sickness coveroge limited to only five or ten years? Or does it cover you to oge 65 os Time plons do?
- Does it demand total disability from the start, or does it compensote you (as Time plans do) if unable to perform the duties of your occupation for 2 to 5 years?
- Are you paying much more premium than you would under a comparable Time plon?

If the onswer to ony of the obove questions is "yes", we suggest you contoct your Time representative without deloy.

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Council Approves Three-Story Addition For State Medical Society Building In Madison

The Council of the State Medical Society, on December 16, approved the construction of a $350,000 addition to the Society building at 330 East Lakeside street in Madison.

Excavation for the three-story addition began on December 19. The addition is scheduled for completion in mid-October.

The new addition, comprising 18,000 square feet of space, will enable the Society to have all its departments in the same building as well as provide additional space for some departments which have outgrown their areas in the present building.

Some functions of the Society are presently housed in the Wisconsin Farm Bureau Building on Madison's south side.

Under the plans approved by the Council, the first floor of the new addition will contain a machine services area, records section and centralized secretarial department.

The second floor will have a lobby area and the claims and underwriting operations of Wisconsin Physicians Service, the health insurance division of the Society.

On the third floor will be a conference room, training room, and auditorium capable of accommodating the House of Delegates. This third floor will be available for future expansion of Society activities.

OPENING OF THE BIDS for the new addition to the State Medical Society building was held on December 12. Pictured above, left to right, are Allen J. Strang, Madison, representing the architects Weiler and Strang and Associates; and the members of the Board of Trustees of the State Medical Society Realty Corporation, Dr. E. M. Dessloch, Prairie du Chien, Dr. H. Kent Tenney, Madison, and Dr. N. A. Hill, Madison. Total cost of the project to add a three-story wing to the west end of the present building will be about $350,000.

The new addition will relieve space problems in the present building in the IBM and machine services areas and provide improved facilities for other departments including the establishment of a library.

Architects for the new addition are Weiler and Strang and Associates and the general contractor is J. H. Findorff and Son, Inc., both Madison firms.

Tuberculosis Study Supported By Division On Chest Diseases

The Division on Chest Diseases of the Commission on State Departments, meeting in Madison December 14, voted to support the initiation of a study by the State Board of Health concerning the care of tuberculosis patients in Wisconsin, with the view of more effective operation of institutions.

The action was an outgrowth of a resolution from the Douglas County Medical Society, referred to the Division by the House of Delegates in the May, 1961, session.

Dr. John G. **Heisel**, Superior, president of the Douglas County Medical Society, appeared before the Division to explain that his society feels there is a need for stronger centralized control of the overall tuberculosis program, and that care might be improved by closing some county institutions and establishing five or six regional facilities for the care of tuberculous patients, without resorting to dual use of institutions.

Appearing for the State Board of Health, Dr. Milton *Feig*, Madison, reported that the Board has decided to initiate such a study early in 1962 and that all interested groups, including the State Medical Society, will be represented.

Upon completion of the study, the Division will review the conclusions and determine what recommendations shall be made to the Council and House of Delegates.

News Briefs

WPS ADDS TO RESERVES

Wisconsin Physicians Service, in the 10-month period ending October 31, 1961, added a total of $394,777 to its reserves, according to Herman L. **Toser**, Insurance Director of the State Medical Society.

SPEAKS AT SAFETY CONFERENCE

Dr. Lawrence L. **Garner**, Milwaukee, Director of the Glaucoma Referral Center and Assistant Clinical Professor at Marquette University School of Medicine, was one of the program speakers at the Wisconsin Mid-Winter Safety Conference and Exposition held January 18–19 in Milwaukee.

Doctor Garner participated in the section on occupational health, speaking on "Glaucoma—The Role of the Nurse."

GOVERNOR NAMES DOCTOR LANIER

Dr. Patricia **Lanier**, Kewaunee, has been appointed to a new state commission to provide leadership and assistance to the many public and private agencies concerned about the problem of the aged and aging.

Doctor Lanier is a member of the State Medical Society's Division on Aging of the Commission on State Departments.

AMA Has Advertising Series For County Medical Societies

A new venture in public service advertising was launched by the American Medical Association early in January.

Every county medical society received the first six in a series of public service messages with the recommendation that these ads be placed in local newspapers.

The ads are simple, straightforward and non-political. Each message is "open end" so that a medical society can add appropriate local information. The first six ads cover these subjects:

Choosing a family doctor
Medical society grievance committees
Doctor-patient relationship
Why MDs promote immunization
Medicine's traditional guarantee of care for all
Cost of medical care

Jim *Reed*, AMA's Communications Division director, says the ads will help medical societies fulfill their educational responsibilities to the public and at the same time improve medical press relations.

"For years newspaper publishers have resented medicine's unwillingness to buy space to tell the people its views on specific subjects. What doctors considered conformity to medical ethics was construed as niggardliness by the press," Reed said.

"Medicine's traditional reluctance to call attention to itself allows many a criticism to go unchallenged. Several medical societies have pioneered by placing institutional ads in local papers. These ads, styled as public service messages, have been extremely well received by the public and the newspaper profession."

The new series of public service ads has long been recommended by AMA's Communications Advisory Committee, composed of representatives from state and county medical societies. The next six in the series, with accompanying art work if societies choose to use it, will be ready early in February.

State Medical Society Announces Details Of 1961 Annual Meeting

Plans for the 1962 annual meeting of the State Medical Society are now in the final stages. The 121st annual meeting will be held May 8–9–10 in Milwaukee at the Hotel Schroeder and Milwaukee Auditorium.

The Tuesday morning program includes Problems of the Female Patient and Cardiology. Afternoon sessions include subjects in Internal Medicine, Obstetrics and Gynecology, Pathology and Psychiatry.

Wednesday morning's program has been planned with the Wisconsin Academy of General Practice. Topics include Automotive Injuries and General Trauma, Closed Chest Resuscitation, and a lecture on Living Attenuated Measles vs. Virus Vaccine. Pediatrics, Orthopedic Surgery and a Special Conference on Medical Aspects of Sports comprise the afternoon slate.

A "wet clinic" on dermatology and allergy will be held Thursday morning. The afternoon program will cover Ophthalmology and Otolaryngology, Anesthesiology, Radiology and Surgery.

A special feature at this year's meeting will be a medical art salon sponsored by the Woman's Auxiliary to the State Medical Society. For further details on the program, turn to pp. 112–114 of this issue.

News Briefs

ORAL POLIO VACCINE

Northwest Wisconsin's first large scale administration of oral polio vaccine was held at Strum on January 17. Sponsored by the PTA, the program was offered to all persons through age 50.

The program was under the supervision of a physician, and individuals who had no previous vaccine were served in the first clinic.

DOCTOR HUTTER AT CONFERENCE

Dr. A. M. Hutter, Fond du Lac, was a participant in the Second National Conference of the Joint Council to Improve the Health Care of the Aged held in Chicago December 8 and 9.

Purpose of the conference was "to focus on the current social, economic and health status of the aged; review selected medical research in aging; present successful voluntary programs in improving health care; and encourage continued participation and cooperation of all community health agencies in meeting the demands and needs of this growing segment of society."

Doctor Hutter is chairman of the State Medical Society's Division on Aging of the Commission on State Departments.

PHYSICIANS IN CIVIL DEFENSE

Three Wisconsin Physicians attended a Management of Mass Casualties civil defense course held at Fort Sam Houston, Texas, October 2–6.

They are: Dr. Joseph N. **Bonner**, Appleton; Dr. Edward P. **Engels**, Rice Lake; and Dr. Raymond R. **Watson**, Milwaukee.

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New Medicare Claim Form Is Now Available

A new Medicare claim form (DA–1863–2) is currently available to Wisconsin physicians and is to be used as soon as current supplies of the old form are depleted.

Physicians can request a supply of the new forms, as in the past, by enclosing the request with a claim to Medicare or by writing to: Medicare, Box 1109, Madison, Wisconsin.

The new form differs considerably in layout, and to a lesser degree in the information required.

New requirements include:

1. In giving the basis for civilian care, when the box indicating "Residing with sponsor—statement presented" is checked, the name of the physician to whom it was presented must be shown on all reports other than the one to which the statement is attached. This refers to reports of the anesthesiologist, radiologist, assistant surgeon, and so forth. The word "statement" refers to the "non-availability statement" or "permit" as used in the past.
2. "Beginning Eligibility Date" must be entered on the form. Complete instructions are given on the back of the new claim form for proper completion of this item.

Complete instructions on the use of the new form are printed on the reverse side and serve as a ready reference when questions arise.

Suggestions On Filing Medicare Claims

Medicare, the government medical care program for dependents of servicemen, resulted in over 6,000 claims submitted by Wisconsin physicians on behalf of their patients in 1961, according to R. E. *Koenig*, Medicare director for the State Medical Society, which administers the program in the state.

This operation has become increasingly important, stated Koenig, with the recall of the 32nd Division to active duty.

With this increased volume, the director pointed out, the quantity of correspondence with physicians in regard to Medicare claims has shown a corresponding increase.

He made the following suggestions, which will spare physicians a large number of the inquiries necessary to secure complete information before claims can be processed:

1. **Have the patient provide insurance and Medicare information on the first visit.**
2. **Have a Medicare claim form completed with patient and sponsor identification and signature of the patient or guardian on the first visit.**
3. **Submit claims promptly.**
4. **Indicate the names of assistant or consultant on initial report.**
5. **When charges are reported for drugs or immunizations, report them at the cost to the physician for the drug or serum. No extra payment is allowable for administration, which the Medicare program interprets as being included in the allowance for the surgical, injury or maternity care in connection with which it is administered.**
6. **Study the instructions on the reverse side of the Medicare claim form and review them when questions arise.**
7. **Do not hesitate to ask the Medicare office at the State Medical Society any questions which remain unanswered.**
8. **Check the "Forum" section of the Wisconsin Medical Journal for notices which will appear as changes and interpretations of benefits and requirements occur.**

Capitol Comment

FUND RAISING REGULATION

A bill, passed by the legislature over Governor Gaylord Nelson's veto, gives the state strong regulatory powers over charitable fund raising campaigns.

The new act exempts fund drives sponsored by accredited educational, religious and patriotic organizations, but groups outside these categories will have to:

1. Register with the Secretary of State's office and pay a $5.00 filing fee.
2. Identify officers and professional fund raisers employed.
3. Provide annual accountings of expenses and contributions.

NEW STATE APPOINTMENT

The State Board of Health has announced appointment of Miss Geraldine Busse, formerly of the Iowa Health Department, as assistant director of the Bureau of Public Health Nursing.

A graduate of the University of Iowa College of Nursing, Miss Busse received her B.S. degree in nursing and science in 1940. She also holds a public health nursing certificate and a master's degree in public health from the University of Minnesota.

AAPS Essay Contest Set

Prizes totaling $2,675.00 will be awarded to high school students in the 16th Annual Essay Contest sponsored by the Association of American Physicians and Surgeons.

In the contest, students in the 10th, 11th, and 12th grades are invited to submit essays on either "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System Over Communism."

County medical societies and auxiliaries are invited to sponsor local competitions in the contest. Otherwise, the students may forward their essays directly to AAPS, Inc., 185 North Wabash Avenue, Chicago 1, Illinois.

Essays must be submitted before March 1, 1962.

WPS Increasing Non-Group Agency System

One of the areas of emphasis for Wisconsin Physicians Service during 1962 will be expansion of the non-group agency system, according to Herman L. Toser, insurance director for the State Medical Society.

WPS, with 27 agents in various communities in the state, started a program January 1 to increase the number in its effort to provide high quality surgical, medical and hospital health care coverage to individuals and families, especially in the smaller communities in the state.

The effort is to reach that large segment of the population which is not offered participation in group plans through their places of employment.

Following are the agents currently selling WPS coverage:

Adams
Tuttle Insurance Agency

Alma
Bautch Insurance Agency

Amery
Granum Agency

Beaver Dam
Paul Cloyd Insurance Agency

Black River Falls
Dimmick Insurance Agency

Eau Claire
Slagsvol–Minton–Jeatran Agency

Genoa City
Bannister Insurance Agency

Kenosha
Gonnering Agency

La Crosse
Federal Insurance Agency

Lancaster
Miles Thompson Insurance Agency

Markesan
Harry Stel Agency

Marshfield
Radtke Insurance Agency

Mauston
Bohen Insurance Agency

Menasha
John Carew Agency

Onalaska
Willson Insurance Agency

Platteville
Kopp Insurance Agency

Racine
Shapiro Agency

Reedsburg
C & J Insurance Agency

Richland Center
Goplin–Armstrong Agency

Superior
Richard E. Erickson

Tomah
Mittlesteadt Insurance Agency

Waukesha
Opsahl Insurance Agency

Wausau
J. N. Manson, Inc.

Wautoma
Ellickson Agency

West Bend
Ed. S. Krieger & Son, Inc.

Winneconne
Schano Agency

Viroqua
Slack–Nelson–Kassel Agency

Some of the agents have been with WPS for a number of years; others have joined within the past few months.

Supporting their individual activities on the local level are outdoor advertising billboards, newspaper advertising, magazine advertising, and displays in physicians' offices.

Any physician within the trade area of any of the agents may obtain a mahogany colored display case, with brochures describing the various forms of WPS coverage available, by contacting the agent. For the most part, except for the new agents, these have been distributed to physicians in the area.

A key part in the success of the agent in his community, according to A. H. Gardner, non-group agency supervisor for the State Medical Society, is the support offered by local physicians.

Radiation Sampling Shows No Danger In Wisconsin

Results of radiation sampling show that everyone in Wisconsin can eat normal amounts of food without worry over radiation, Dr. Carl N. Neupert, State Health Officer, said December 18.

Results of daily analysis of food samples for radioisotope content show no present need for concern over excessive radiation of milk or other foods in amounts consumed in a normal diet, he stated.

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37CL—Cuff Links

ASKLEPIOS COIN
36.7KC—Key Chain
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SALUS COIN
Goddess of Health
39CL—Cuff Links
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Report Growth Of Community Health Clinics

Considerable growth and development of community mental health clinics in Wisconsin has been reported by Dr. Leonard J. Ganser, director of the Mental Hygiene Division of the Department of Public Welfare.

The developments have included approval of four new clinics for grants-in-aid, and expansion of services in existing clinics.

State-aided clinics are now operated in 17 localities, serving 18 counties: Brown, Dane, Dodge, Douglas, Eau Claire, Fond du Lac, Grant, Kenosha, Manitowoc, Milwaukee, Outagamie, Racine, Sheboygan, Walworth, Washington–Ozaukee, Waukesha, and Winnebago.

In addition, a number of communities are working toward the development of clinics or in expanding present programs to qualify for state aid.

Polk and Barron counties are jointly planning a clinic. The Rock County Board is evaluating the need to increase its clinic staff and services to receive state aids. Wood and Portage counties are working toward development of a clinic, and a number of other counties have expressed an interest and are in the initial stages of evolving facilities.

Working directly with the counties is Dr. Kenneth H. Rusch, who joined the Division of Mental Hygiene staff in August as Director of Community Mental Health Clinic Services. John M. Riley joined the Division staff in February, 1961, as social work consultant to the community clinics, and a position of psychologist consultant remains to be filled.

STATE SOCIETY OFFERS AIDS ON
Health Care Of The Aged

Legislative action on the social security concept of providing financial assistance for medical care of the aged has reached a stage where local action is highly important.

With Congress back in session, and the King–Anderson proposal on the "high priority" list of the administration, the bills could come up for action at any time in the future.

The following aids are available from the State Medical Society, 330 East Lakeside Street, Madison, Wisconsin, for use in local public and medical society educational programs.

1. **Motion Picture**
   Dr. Edward R. Annis, Miami, Florida, interviewed by Jerry Deane, news director of station WISC–TV, Madison, on the subject of financing health care for the aged. Suitable for showing to medical or non-medical audiences. 16 mm film, black and white, 15 minutes.
2. **Tape Recording for Medical Meetings**
   A speech by Dr. Edward R. Annis before the annual County Medical Societies Presidents' and Secretaries' Conference, March 22, 1961, on the subject of health care for the aged. This recording is for physician audiences only. 28 minutes.
3. **Tape Recording for General Public**
   An interview with Dr. Edward R. Annis and Dr. H. Kent Tenney, Madison, on the subject of health care for the aged. Suitable for playing before medical and non-medical audiences. 28 minutes.
4. **Testimony of the State Medical Society of Wisconsin before the House Ways and Means Committee.**

AMA Educational And Research Foundations Combined Jan. 1

The American Medical Association has announced the formation, effective January 1, of the American Medical Association Education and Research Foundation (AMA–ERF).

The new organization combines the American Medical Education Foundation and the American Medical Research Foundation.

At the same time the two organizations were combined, their programs were expanded, and a concerted effort will be made to provide increased financial assistance to medical schools, in addition to financing the other projects of the Foundation.

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ROBERT N. RANDALL • *Executive Director* • AL 7–2012

Minutes of Council Meeting

Land O'Lakes, July 28–29, 1961

1. Call to Order and Roll Call

The Council was called to order by Chairman Fox at 2:10 p.m. on Friday, July 28, at King's Gateway Inn, Land O'Lakes, Wisconsin.

Councilors present were Doctors James, Schulz, Nordby, J. H. Houghton, Blanchard, Kief, Fox (Friday only), Bell, Mason, Frank, Ekblad, Egan, W. J. Houghton, Van Hecke, Willson, Curran, and Past President Sorenson.

Officers and others present were President Lokvam President- elect Hill, Vice Speaker Carey, Doctors Simenstad (Saturday only), Bernhart, and Galasinski, delegates to the American Medical Association, Doctor Sullivan, alternate delegate, and Dr. R. B. Larsen, chairman of the Commission on Scientific Medicine (Friday only); Messrs. Crownhart, Thayer, Ragatz, Toser, Murphy, Tiffany, Gill and White; Mrs. Anderson; Misses Rendall and Pyre.

2. Approval of Minutes

Minutes of the April 30 regular meeting and the June 18 special meeting had been distributed in advance of the July meeting.

Doctor Willson said he realized it was most difficult to summarize completely the discussion at the special meeting on building problems, but thought that some mention should be included of the discussion on costs.

On motion of Doctors Nordby–Frank, carried, minutes of the two meetings were approved with the following addition to the June 18 minutes:

"Question was raised as to whether the addition would have any impact on the dues structure, and in particular the third floor which is contemplated for meeting purposes initially. The Secretary on request stated that details on proposed use would be reported at a later meeting."

3. King–Anderson Legislation

Mr. Murphy reported that he was accompanying Dr. Robin Allin to Washington, where the latter would appear during the following week before the House Committee on Ways and Means in opposition to H. R. 4222.

4. AMA Delegates Report

The delegates and staff in attendance at the June meeting of the AMA discussed with the Council at considerable length actions taken at that meeting with particular reference to chiropody, osteopathy, and medical discipline.

Council action, on motion of Doctors James–Nordby, carried, was to refer the matter of chiropody to the Committee on Scientific Medicine, and the matters of osteopathy and medical discipline to the Planning Committee for further study.

5. Report of Commission on Scientific Medicine

R. B. Larsen, M.D.: It is my pleasure to bring to you a synopsis of the work of the Commission on Scientific Medicine during the past year and to briefly outline our plans for the year 1961–62. The work of the Commission has been enhanced during the past year by the close cooperation afforded by the Scientific Committee of the Council of the State Society. We were fortunate that at the initial meeting of the Commission on July 16, 1961, Doctors Bell, Curran and Sorenson could be with us for counsel and advice. It is our hope that this liaison and cooperation will continue to expand.

The format of the 1962 program was outlined and prepared by your Commission two weeks ago with the active cooperation of representatives from the Wisconsin Academy of General Practice, as well as from the various specialty societies. The broad outlines of the program have become defined and the initial invitations for guests and speakers have already been dispatched.

The Commission has some specific recommendations which we would like to bring to the attention of the Council, and at this time would like to present these recommendations to the Council for necessary action. The House of Delegates has already acted concerning participation of members only in programs of the State Medical Society, and the Commission considering these proposals in reference to the annual meeting, both as to the speakers and exhibits, approved the following rules for presentation to the Council.

A. Speakers and Round Table Leaders:

No physician who has completed his residency, and is either in practice in the State of Wisconsin, or on the faculty at the University of Wisconsin or Marquette University School of Medicine, shall appear on the annual meeting program unless he is a member of the State Medical Society of Wisconsin.

Exception: If the Commission on Scientific Medicine wishes a non-member physician (though eligible for membership) to speak, approval of the Council shall be required.

B. Scientific Exhibits:

No non-member of the State Medical Society of Wisconsin, if he qualifies for membership in the State Society, shall be a "primary author" of a scientific exhibit displayed at the annual meeting.

C. Resident Participants:

Any resident may appear on the program, whether member or not. If a resident member, his name shall appear on the program in the normal manner. If not a resident member he must appear under the sponsorship of a member, and the name of the resident and sponsor shall appear on the program.

Previous action has also established the resident membership in the State Society and it was the consensus of the Commission that hospitals should be acquainted with the desirability and availability of such memberships; further, that they be encouraged to have their residents become members and perhaps defray the cost of such membership so that the residents will receive the Journal and are eligible to appear on the program of the annual meeting without other sponsorship.

Considerable discussion was devoted to the length of the meetings in the spring, and it is further recommended by the Commission that the House of Delegates meet in the fall, but that the scientific meetings continue to be held in the spring. It is also the consensus that the spring meeting be shifted to the second week in May, as soon as possible, thus avoiding conflict with the annual Research Conferences held the first week in May, and still allowing coordination with the Minnesota meeting, which is held the third week in May.

The Commission is pleased to present a full report on the speakers service for the past year and copies have been distributed to Council members. The Commission has reviewed this program, and has modified it somewhat for the next academic year, restricting the service to all months except April and May so that during this period major attention can be given to actions coming before the House of Delegates in April, with the May meeting devoted to reports of the delegates, as well as implementation of actions which are of direct concern to county organizations.

The Commission is likewise encouraging counties to direct some of their meetings to related activities such as legislation, insurance programs, meetings with related professions, etc. It is further hoped that by encouraging counties to conduct varied programs, four to six meetings a year of a scientific character can be carried out.

In addition to the plans for the annual meeting of next year, as well as the speakers service to the county societies which has briefly been reviewed, the Commission has several other projects, either completed or pending, which it is pleased to report.

A. Circuit Teaching Programs: Ten meetings, consisting of five "circuits", are being planned between September and February.

Current plans call for afternoon scientific programs in Marinette, Waupaca, Ashland, Rhinelander, Dodgeville, Beaver Dam, Viroqua, Portage, Elkhorn and Oconomowoc. While presentations will cover a variety of subjects, special attention this year is being directed to pathology as related to clinical practice. Through the cooperation of the Wisconsin Society of Pathologists, special attention will be directed to "Newer Tests of Interest and Concern to the Generalist."

While these meetings are not large, they serve a definite purpose and bring to the regional level an organized program of the State Society through its Foundation and serve to introduce to the practicing physicians some of the newer members of the faculties of our two universities.

Through the cooperative support of the Wisconsin Heart Association, the State Board of Health, the Wisconsin Division of the American Cancer Society, the W.A.T.A., and the Postgraduate Teaching Program of Merck Sharp and Dohme, these programs as well as those of the speakers service have been provided as a service of the Society with relatively very little cash expenditure from the dues structure.

B. Through the Division on Maternal and Child Welfare the study of all maternal deaths continues in its seventh year of operation. The study committee members and special invited guest speakers have provided fourteen interpretive programs for physicians and hospital personnel since 1958. A total of 1,630 persons have participated in these teaching programs. Of this total 868 were physicians and the balance were hospital personnel, residents and medical students serving their preceptorships in each of the specific communities where the programs have been held.

In 1961 programs were held in Green Bay and Wausau, upon special invitation of the Regional Units of the Wisconsin Academy of General Practice. 272 persons attended these two meetings.

The Commission is impressed with this study, both in terms of the opportunity for physician education as well as an avenue for good public relations involving hospital personnel.

C. This past year the Division on Nervous and Mental Diseases through the Foundation, and with financial support of the Wisconsin Association for Mentally Retarded Children, presented a very successful conference in Milwaukee on "Medical Aspects of Mental Retardation." Over 200 persons attended this meeting and again it had double benefits, in terms of physician education and important contacts with many parent groups deeply concerned with this specific field. It has resulted in the generation of good will, particularly from lay groups who appreciate the Society's efforts in this area of medical practice and family counseling.

D. During the coming year, in addition to the services already outlined, a special conference on "Problems of the Newborn" will be presented in Wausau on September 13, cooperatively with the Wisconsin Valley Chapter of the Wisconsin Academy of General Practice.

E. Initial steps are contemplated for the development of a one or two day conference on "Medical Problems in the Care of Geriatric Patients." This important area of medical practice we feel should be discussed at a conference jointly sponsored by the Commission on Scientific Medicine, Wisconsin Hospital Association, our Division on Aging, as well as with the appropriate state agencies. This field, involving a rapidly increasing segment of our population, deserves vigorous leadership from our Society. A strong effort in this direction will afford us the opportunity of formulating plans with other agencies at the outset, as well as providing a public relations image in a field with which we had not heretofore been closely identified.

It is impossible to summarize all the activities which are of concern to the Commission on Scientific Medicine. The Council periodically receives reports on the affairs of the Wisconsin Medical Journal through Mr. Crownhart, as well as from Doctor Baldwin. In spite of economies necessary in the Journal because of the decline in advertising revenues, the scientific aspect of the Journal has been maintained and we feel sure contributes to the education of our Society members.

It is appropriate at the present time to bring yet another recommendation to the Council. Doctor Victor Falk has become an assistant editor of the Journal, leaving a place in the Editorial Board to be filled through appointment by the chairman of the Council. The Commission on Scientific Medicine has transmitted with pleasure the nomination of Doctor M. C. F. Lindert of Milwaukee to Doctor Fox as our nomination. Doctor Lindert has just completed his fifth year as a member of the Commission on Scientific Medicine during which time he has taken a great interest in the scientific content of the Journal.

The Commission has continued enjoying the closest of cooperation with our two state medical schools and are deeply appreciative of the aid in planning extended by Dean Hirschboeck and Dean Bowers all

of the time. We likewise have enjoyed the unusually fine support of Doctor Carl Neupert and his staff on the State Board of Health.

The members of the Commission have felt that we are keeping pace with the needs of our members in scientific affairs and hope that the many programs so briefly mentioned in this report will help to keep our full membership abreast of current treatment and research. We also feel that we should strive for steady progression and, therefore, sincerely would welcome suggestions from all of you gentlemen which may enable the Commission to be of increasing service to the membership. We appreciate deeply the opportunity afforded to present this report.

———

Doctor Galasinski suggested that the Commission plan a program at the annual meeting on athletic injuries, with portions of it directed, and invitations extended, to high school coaches.

The Council took action as follows on the several recommendations of the Commission on Scientific Medicine:

A. Speakers and Round Table Leaders:

To implement action of the House of Delegates concerning participation of members only in programs of the State Medical Society, the rule of the Commission on Scientific Medicine was accepted as follows:

> No physician who has completed his residency shall appear on the Annual Meeting program unless he is a member of the State Medical Society of Wisconsin.

On motion of Doctors Bell–Nordby, carried, the proposed exception to this rule was adopted as follows:

> *Exception:* If the Commission on Scientific Medicine wishes a non-member physician (though eligible for membership) to speak, approval of the Council shall be required.

B. Scientific Exhibits:

No non-member of the State Medical Society of Wisconsin, if he qualifies for membership in the State Society, shall be a "primary author" of a scientific exhibit displayed at the Annual Meeting.

On motion of Doctors Bell–Kief, carried, the above rule was adopted.

C. Resident Participants:

Any resident may appear on the program, whether member or not. If not a resident member, he must appear under the sponsorship of a member, and the name of the resident and sponsor shall appear on the program.

Any resident who is a resident member of the State Medical Society need not have a sponsoring member.

On motion of Doctors Bell–Curran, carried, the above rules were adopted.

D. Encouragement of Resident Memberships

On motion of Doctor Bell, seconded and carried, the Council recommended that hospital chiefs of staff be written urging that residents become resident members of the State Medical Society.

E. Annual Meeting Dates

Accepting the practical impossibility in the near future of returning to a fall date, Doctors Bell–Mason moved that efforts be concentrated on the second rather than the first week in May.

Motion carried.

F. Two Meetings of House of Delegates

Doctor Bell pointed out that the Council and its committee on Scientific Medicine have discussed the advisability of having a separate fall meeting of the House of Delegates; and to initiate steps to attempt to achieve this, he moved that a bylaw amendment be proposed to the House of Delegates. Motion seconded by Doctor Ekblad.

In answer to an inquiry, it was proposed that the May meeting of the House would be to receive reports, elect officers and appoint committees, and at the fall meeting the main business of the Society would be conducted. This meeting could be held in various areas of the state.

Doctors Willson–Kief offered an amendment that this proposal be referred to the Planning Committee for consideration and report back to the Council.

Motion carried as amended.

On motion of Doctors Bell–Blanchard, carried, Doctor Larsen's report was accepted with commendation.

6. Housing of Society Activities

Secretary Crownhart reported progress since the special meeting in June. He said that an appraisal had just been completed, which was required to support financing, and showed a total replacement value of the property, land and improvements, of $515,700, or $22.96 per square foot as against construction cost of approximately $17.00. He said that considerable time had been spent in planning departmental locations in the existing building and the addition; reported on conferences with the architects; and said they hoped final specifications would be ready for bidding early in November, which would probably mean a special Council meeting sometime in December for action on the bids as specified in Doctor Willson's motion.

After some discussion and questions, Chairman Fox suggested that detailed discussion be held until actual cost figures, etc. were available, and said that every effort would be made to supply the information in advance of a special Council meeting.

7. Report of Executive Committee

Chairman Fox asked Secretary Crownhart to give an oral report of actions of the Executive Committee the prior evening, some of which related to items on the Council agenda:

A. Organization of State Medical Society

The Committee reviewed organization charts prepared by the staff and recommended that they be referred to the Planning Committee for further study and probably preparation of text before they are presented to the Council.

B. Name of Grievance Committee

The committee requested opinions of councilors as to the advisability of recommending a name for this committee such as "Judicial Commission."

After discussion, on motion of Doctors Willson–Nordby, carried, the subject was tabled.

C. A. H. Heidner, M.D. and AMEF

The committee was advised that Doctor Heidner wished to be relieved of positions he has held on the Committee for Improvement of Patient Care, the Wisconsin Welfare Council, and the AMEF state chairmanship. It recommended to the Council that he be urged to remain in the

latter position, and would be replaced on the others in due course.

The Council heartily approved the recommendation.

D. Arbitration Board

The committee recommended that the resolution from the sixth councilor district requesting study of the creation of a medical-legal arbitration board, be referred to the appropriate Council committee for further study.

On motion of Doctors Nordby–Bell, carried, it was referred to the Committee on Economic Medicine.

E. Congress on Medical Quackery

The committee recommended that Doctors R. G. Zach and Robert Samp be sent at Society expense to the AMA Congress on Medical Quackery.

On motion of Doctors Curran–Egan, carried, the recommendation was approved.

F. Advisory Committee to Review Vital Statistics Laws

On motion of Doctors James–Blanchard, carried, the Council approved the committee's authorization of Doctor Hill to select an appropriate physician to represent the Society on this State Board of Health committee.

G. Group Insurance for Society Members

The committee recommended that in light of frequent contacts by insurance companies with various proposals for group insurance, the Society should have a broker of record, chosen by management, to serve largely as a consultant to the Society on group insurance.

On motion of Doctors Nordby–Egan, carried, the recommendation was approved.

H. Reference Committee Hearings

On motion of Doctors Egan–Blanchard, carried, the Council approved the recommendation that an official mechanism be worked out to secure attendance at reference committee meetings of the House of Delegates by committee chairmen to discuss their reports.

I. Election of Assistant Treasurer of Society

On motion of Doctors Kief–Mason, carried, John T. Sprague, M.D., recently elected treasurer of Wisconsin Physicians Service was confirmed as an assistant treasurer of the Society to succeed Doctor Hill.

J. Raymond P. Welbourne, M.D., 1914–1961

On motion of Doctor Frank, variously seconded and carried, the Council accepted the recommendation of the Executive Committee that there be spread upon the records of the Council the following resolution of recognition of R. P. Welbourne, M.D., deceased:

> WHEREAS, Raymond P. Welbourne, M.D., of Watertown, Wisconsin, served with unusual devotion and exceptional ability his patients, the profession of medicine, and the cause of better health; and
>
> WHEREAS, His efforts on behalf of cancer control produced benefit beyond measure in the relief of suffering and the education of the public; and
>
> WHEREAS, His distinguished contributions to the medical profession, to his community, and the state, have enhanced the welfare of great numbers of our citizens; therefore be it
>
> *Resolved*, That the Officers and members of the Council of the State Medical Society of Wisconsin, in meeting July 29, 1961, place on record this appreciation of his life and influence.

K. Salary of State Health Officer

The committee recommended adoption of a resolution intended to express to the Legislature the Society's support of the Governor's bill to raise the salary level of this position in order to acquire and retain competent personnel.

On motion of Doctors Nordby–Schulz, carried, the Council adopted a resolution to the following effect, with appropriate introductory statements:

> *Resolved*, That the Council of the State Medical Society of Wisconsin support a bill drafted on the initiative of the Governor to establish a higher salary range for the State Health Officer and other heads of state departments, deeming it a matter essential to both the immediate and long-range health and related needs of the entire population of the state.

L. Committee Appointments

It was reported that President Lokvam would announce several standing committee appointments on Saturday for Council ratification.

Chairman Fox announced the appointment of M. C. F. Lindert, M.D. to a vacancy on the Editorial Board, on recommendation of the Commission on Scientific Medicine. He also suggested that the Council on Saturday elect a vice chairman, a position authorized in the bylaws some time ago.

K. Meeting with Nurses

The committee reported that it would meet in the near future with representatives of the Wisconsin Nurses Association and their official body.

8. Election of Chairman of Division on Safe Transportation, Commission on State Departments

On separate motion duly made, seconded and carried, the resignation of Dayton Hinke, M.D., as chairman of this Division was accepted, and R. B. Windsor, M.D., of Sheboygan, was nominated and unanimously elected to succeed Doctor Hinke.

9. Report of Legal Counsel

Mr. Murphy discussed major projects in which the law office was involved during the past year, other than its sustained efforts in public health legislation and Wisconsin Physicians Service legal matters, on the following subjects: rewrite of the January "blue book" issue of the Journal; Chapters 301, inspection of medical records; 484, revision of fee splitting statute; and 602, regulation of "Blue" plans, of the 1959 Legislature; Kerr–Mills implementation in Wisconsin; Personal Service Corporations; and studies relating to proposed radiation control legislation.

The Council recessed at 4:35 and reconvened at 2:05 p.m. on Saturday, July 29, President Lokvam presiding.

10. Implementation of Report on Washington Trip

Doctor Frank reported that the Planning Committee that morning had considered portions of the report of the special delegation which fall within its area of activities, and made the following recommendations to the Council:

A. Distribution of AMA News

On motion of Doctors Frank–Blanchard, carried, the Council approved the Planning Committee's recommendation that the AMA News be distributed to a non-medical mailing list of 1,000 to 1,500 to be made up by the staff, and including, tentatively, the state legislators, key people in various state departments, representative groups among hospital boards of trustees, hospital administrators, pharmacy and dentistry, and newspapers.

B. Medical Social Service

The special delegation recommended, in summary, that the Society immediately undertake a study of the means for establishing a medically sponsored social service program to supply the people of Wisconsin with acceptable and reliable information and assistance in obtaining medical care and solving related health problems.

While the Planning Committee had no concrete recommendation to make at this time, Doctor Frank reported its discussion of the possibilities of county medical societies creating special committees on the medical social service problem; of creating a field staff to correlate activities of the county societies and the State Medical Society; of conducting "listening post" meetings around the state; and of utilizing a type of questionnaire for county society officers to report specific problems.

He said that the committee had not had opportunity to thoroughly discuss the public information and public health portions of the report, but that these matters were all inter-related.

11. Organization of the State Medical Society

Doctor Frank asked Secretary Crownhart to present the organization charts referred to Planning by the Executive Committee. The committee proposed that the charts be amplified with descriptive text and an introduction stating the philosophy of the structural organization of the Society, and published in pamphlet form or, possibly, in the January "blue book" issue of the Journal. This will come back to the Council for final action.

12. Report of Commission on Medical Care Plans and Consultants

A. Financial Statements for May 1961

These were distributed and reviewed by Mr. Toser in the absence of Doctor Dessloch, who found he could not be present. Operations for the month resulted in a contribution to reserves of $25,055.53, and the overall loss ratio for the first five months of 1961 was 88.13 as compared with 92.43 for the same period in 1960.

B. Report of Insurance Director

Mr. Toser went on to report a few highlights of WPS operations in terms of 1961 objectives and the current outlook for their attainment. Premium objective is $10,000.000 and it appeared that at least $9,600,000 would be attained. New business acquisition still is disappointing, but there have been recent indications of improvement. Local agencies are being utilized more and more, and there will be additions to the WPS sales staff concentrating on new business. Operating expenses are running somewhat under the objective, and might show even greater improvement with all employees "under one roof." Contract revisions are currently under study by staff and consultants, and it is hoped that recommendations may be made to the Commission in the near future. He also commented on the creation of a research function within the staff.

C. Report of Consulting Actuary

Mr. Tiffany reported that ratewise WPS has experienced a relatively stable year over those following entrance into the hospital business. He discussed the elaborate statistical system utilized to constantly evaluate experience under the rating structure, which involves approximately 40 different rating classes as represented in the various types of contracts available. He said that his review of current experience and trends indicated rate adjustments in 4 or 5 areas. Based on a sample study only, he said there was some cause for concern over the increase in average payments under the Special Service contract, but that further studies would be made before reporting to the Commission.

D. Recent Developments in Racine, Kenosha and Milwaukee Counties

Secretary Crownhart discussed recent developments in these counties, and elsewhere in the state, indicating the growing possibility of various types of union health or diagnostic centers moving into Wisconsin. General discussion followed. The Commission on Medical Care Plans is studying this matter both as one of concern at all levels of medical organization and as ultimately involving voluntary insurance.

13. Further Report of Planning Committee

Doctor Frank reported that the committee has undertaken the review of county society constitutions and bylaws and preparation of a "model" is in preparation. The following matters were presented for Council action:

A. Definition of "Clinic"

The Planning Committee has discussed this assignment on two occasions and concluded that in view of the wide and varied use of the term in the state, it is impossible for the committee to define the word in any specific terms, and it simply suggests that the term be used by physicians in an ethical and proper manner. Doctors Frank–Blanchard moved that the matter be dropped.

Following discussion, the motion of Doctors Frank–Blanchard was tabled on motion of Doctors Curran–Schulz, carried.

B. Community Health Program of Wisconsin Junior Chamber of Commerce

Doctor Anderson of Cumberland had offered assistance of the Junior Chamber of Commerce in promoting a mass oral polio vaccination program in Wisconsin.

The Planning Committee recommended that the JCC be encouraged in their desire to help the public receive vaccination against polio but that no specific mention of oral polio vaccine should be made and it should be pointed out that other types are available; also that they should work closely with their local physicians through the county medical societies rather than the state organization.

On motion of Doctors Frank–Nordby, carried, the recommendation was approved.

14. Report of Committee on Economic Medicine

Doctor Egan presented the following report on this Council committee's meeting of July 28, intended as informative only at this time:

A. Review of Duties and Purposes of the Committee

The committee, organized by Council action of May 5, 1957, is charged with the responsibility "to follow and evaluate programs of the Society in the field of economic medicine, and to make recommendations to the Council which are designed to make such programs of maximum interest and significance to the profession."

It was agreed by the committee that it would consider matters referred directly by the Council or through individual members of the committee, especially with regard to doctor-patient-economic relationships and physician economic problems.

B. Organization of the Committee

a. On motion of Doctors Blanchard–Willson, Doctor Houghton was elected vice chairman.
b. On motion of Doctors Houghton–Schulz, Doctor Blanchard was elected secretary to act in liaison with physicians and staff on committee matters.
c. Following discussion, it was decided that four regular meetings of the committee would be called one month in advance of Council meetings with special meetings called as necessary.

It was further suggested that agenda and other material of interest be distributed to the committee as it becomes available.

C. Personal Service Corporations—Bill 587, A.

Mr. Murphy reported that Bill 587, A., regarding state legislative machinery for establishment of professional corporations had passed both houses of the Legislature and awaited the Governor's signature.

It was determined that this was a matter of business under jurisdiction of the committee and that implementation should be studied for report to the Council. Further, it was agreed that Doctors Egan and Houghton should have primary responsibility of this subject.

D. Hospitol Pharmacies

Doctor Egan, at the request of the committee, will undertake the study of problems in this area, reporting back to the committee at a future meeting.

In addition, legal counsel was requested to offer advice and opinions on recent rulings of the State Board of Pharmacy.

E. Redevelopment of Interprofessional Institute

The last such institute was organized with allied professional organizations in 1955, and staff was requested by the committee to prepare a report evaluating the need, value and cost of reestablishing such an institute.

It was also suggested that such a study involve potential of such allied professions sharing the costs of an institute of this type.

F. Study of Comprehensive Personal Liability Insurance Proposed on a Group Basis

The committee asked that presentations from companies interested in promoting such policies be obtained for review by the committee.

G. Medical (Non-Surgical) Costs Related to Workmen's Compensation

The committee urged that information regarding this subject be gathered in association with allied groups and be made a matter of study by the committee.

H. Advising Members of SMS of Narcotic Addicts, etc.

It was the opinion of the committee that this was not a matter properly before it, and therefore recommended that the subject be referred back to the Council with the suggestion that this might more properly be handled by another committee.

I. Business Management Services

The question of whether a study of business management services in Wisconsin should be made was discussed by the committee.

In this regard Mr. Murphy enumerated three areas of concern:

a. whether the job is being done well;
b. whether this is an area to be regulated by law; and
c. whether such services should be made available to the membership through the Society or under its control.

It was concluded that this was a matter which should be studied and further information provided the committee.

On motion of Doctors Curran–Blanchard, carried, the report was accepted.

15. November Council Meeting at AMA Headquarters

Secretary Crownhart announced that this meeting had been set for November 18–19, and summarized his correspondence with Doctor Blasingame regarding the AMA portion of the program. He asked that Councilors let him know of any particular subject they would like discussed.

16. Election of Vice-Chairman of the Council

On nomination of Doctor Curran, variously seconded and carried, John M. Bell, M.D., was elected Vice-chairman of the Council.

17. Committee Appointments

Doctor Lokvam announced that J. M. Sullivan, M.D. had resigned from the Commission on Public Policy and he wished to appoint H. E. Oppert, M.D. of Viroqua.

On motion of Doctors Ekblad–Frank, carried, the appointment was confirmed.

Doctor Lokvam proposed to appoint C. A. Olson, M.D. of Baldwin to the Commission on Public Relations and Communications to fill the vacancy caused by the resignation of D. M. Willison, M.D.

On motion of Doctors Van Hecke–Nordby, carried, the appointment was confirmed.

18. July 1962 Meeting Place

On motion of Doctor J. H. Houghton, seconded by Doctor James and carried, the Council voted to return to King's Gateway next year.

19. Report of Certified Public Accountants

Mr. White described the activities of Donald E. Gill & Co. around the theme that every action of the Council and other bodies has a reaction in the flow of funds, both in and out of the Society. The firm acts in three capacities: auditors; consultants; and specialized resource personnel on specific matters.

20. Report of Finance Committee

Secretary Crownhart reported the following recommendations:

A. Advance to Foundation

In view of the lack of Foundation funds to meet loan applications before the fall term, and the committee's recognition of this very worth-while project, it is forced to recommend that an advance be made to the Foundation from the general funds of the Society in the amount of $6,000. The money is to be repaid after the fall billing, and receipt of a bequest from the estate of Florence Duckering, M.D. in the amount of $5,000.

On motion of Doctors Bell–Curran, carried, the recommendation was approved.

B. Pension Plan Bank Account—Authorized Signatures

Currently the only two authorized signatures for checks are E. M. Dessloch, M.D., and C. H. Crownhart. With the acquisition of investment counsel and the need to proceed promptly on his recommendations, the Finance Committee recommended that the following additional signatures be authorized:

Drs. F. L. Weston, J. T. Sprague, and E. J. Nordby; Messrs. Ragatz and Thayer.

On motion of Doctors Egan–Van Hecke, carried, the recommendation was approved.

C. Executive Session

21. Adjournment

The Council adjourned at 4:10 p.m. on Saturday, July 29, 1961.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M.D.
Chairman

SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1962–June 30, 1962

STATE DEPARTMENT OF PUBLIC INSTRUCTION, BUREAU FOR HANDICAPPED CHILDREN
CRIPPLED CHILDREN DIVISION, MADISON 3, WISCONSIN

LOCATION	*DATE*	*LOCATION*	*DATE*
Ashland	February 7 and 8	Chippewa Falls	April 25 and 26
Manitowoc	February 14 and 15	La Crosse	May 2 and 3
Racine	March 7 and 8	Superior	May 17
Marinette	March 14	Sheboygan	May 23 and 24
Kenosha	March 21 and 22	Rhinelander	May 31 and June 1
Eau Claire	April 5 and 6	Lancaster	June 7
Wausau	April 10	Darlington	June 14

FOR: The clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examination are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinics so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

"Something Important For Every MD" At 1962 Annual Meeting In May

Working closely with the various specialty societies and the Wisconsin Academy of General Practice, the Commission on Scientific Medicine has prepared an outstanding program for the Annual Meeting in Milwaukee, May 8–9–10. To give you an opportunity of planning your attendance, the outline of the Scientific Program is included in the January and February issues of the JOURNAL. The March issue will include full details, and *around the latter part of March a special announcement on the noon scientific luncheons will be sent you.*

PLAN NOW TO ATTEND, AND MARK YOUR CALENDAR FOR THESE DATES

TUESDAY, MAY 8

1. **Morning General Program:** ("Your Female Patient and Special Problems She Presents")

   A. ENDOCRINE ASPECTS OF ENDOMETRIAL ADENOCARCINOMA
   Richard E. Mattingly, M.D., Milwaukee
   Edmund R. Novak, M.D., Baltimore
   Robert E. Scully, M.D., Boston

   B. THE MEDICAL AND SURGICAL COMPLICATIONS OF PREGNANCY AND THE ROLE OF THE INTERNIST
   Ben M. Peckham, M.D., Madison
   Alan Guttmacher, M.D., New York City
   Ralph Reis, M.D., Chicago
   Charles L. Junkerman, M.D., Milwaukee

2. **Special Morning Program on Cardiology**
   ACUTE DIFFUSE VIRAL MYOCARDITIS: Robt. A. Miller, M.D., Chicago
   SURGICAL TREATMENT OF CONGENITAL HEART DISEASE: Ormand C. Julian, M.D., Chicago
   SGOT AND LDH TESTS IN ACUTE MYOCARDIAL INFARCTION: John H. Huston, M.D., Milwaukee

3. **Noon Luncheons:**
   Luncheons of Marquette and U. of W. Alumni Associations, plus 3 scientific luncheons (ob, pathology, psychiatry). **Special notice on scientific luncheons to reach you in March.**

4. **Afternoon Scientific Programs:**
   A. INTERNAL MEDICINE:
   Arthur M. Master, N. Y. City: "The Master '2-Step' Exercise Electrocardiogram"
   B. OBSTETRICS & GYNECOLOGY:
   Alan Guttmacher, M.D., N. Y. City: "Cesarean Section in Twin Pregnancy"
   Edmund R. Novak, M.D., Baltimore: "Stein Leventhal Syndrome"
   Panel on "Induction of Labor": **Drs. Guttmacher and Reis**
   C. PATHOLOGY:
   Robert E. Scully, M.D., Boston: "Germ Cell Tumors of the Ovary"
   George L. Wied, M.D., Chicago: "Cytometry and Routine Cytological Examinations"
   D. PSYCHIATRY:
   Maurice E. Linden, M.D., Philadelphia (Title later)

WEDNESDAY, MAY 9

1. **Morning General Program** (Planned with Academy of General Practice)
   G.P. CREDIT: The Wednesday program has been planned with the Academy and provides 6 hours of Category I Credit. Choice of afternoon programs as listed below.
   Morning program will cover general topics of "Automotive Injuries and General Trauma" and "Closed Chest Resuscitation," **see March Journal for details,** and a lecture on "Living Attenuated Measles vs. Virus Vaccine" by Fred R. McCrumb, Jr., M.D., Baltimore

2. **Noon Luncheons** (Details to reach you in special March mailing)
   Luncheons on pediatrics, (Wm. Oliver, M.D., Ann Arbor); obstetrics (Edmund Novak, M.D., Baltimore); antibiotic therapy (B. A. Waisbren, M.D., Milwaukee); orthopedics (A. W. Humphries, M.D., Cleveland); public health (Fred R. McCrumb, Jr., M.D., Baltimore) and several others.

3. **Afternoon Scientific Programs:**
   A. PEDIATRICS:
   Donald E. Cassels, M.D., Chicago: "Rheumatic Fever and Rheumatic Heart Disease"
   William T. Oliver, M.D., Chicago: "Acute Nephritis in Children"
   Harold Borenz, M.D., Madison: "Children's Personality Reactions to Chronic Disease"

   B. ORTHOPEDIC SURGERY:
   Joseph M. Janes, M.D., Rochester, Minn: "Amputation in Occlusive Vascular Disease"
   A. D. Humphries, M.D., Cleveland: "Reversibility of Pre-Gangrene in the Severely Ischaemic Limb"

   C. SPECIAL CONFERENCE ON "Medical Aspects of Sports" Are you the "team physician" in your local high school? If so you are asked to make a special effort to be at this portion of the program. **Details in the March Journal**

THURSDAY, MAY 10

1. **Morning General Program** ("Wet Clinic" on Dermatology and Allergy)
   Cases to be provided by Milwaukee MDs associated with the Wisconsin Dermatologic Society and the Wisconsin Society of Allergists. Guest Discussants:
   Leon Goldman, M.D.: Cincinnati
   Adolph Rostenberg, Jr., M.D., Chicago

2. **Noon Luncheons.** (Details to reach you in special March mailing)

Luncheons on surgery (C. B. McVay, M.D., Yankton, S. D.; radiology (John A. Evans, M.D., N. Y. City); anesthesia (John Severinghaus, M.D., San Francisco); dermatology (Leon Goldman, M.D., Cincinnati); allergy (Adolph Rostenberg, Jr., M.D., Chicago); obstetrics (Richard Mattingly, M.D., Chicago) and several others.

3 **Afternoon Scientific Programs:**

A. SECTION ON OPHTHALMOLOGY & OTOLARYNGOLOGY

(Starts with luncheon at Hotel Schroeder)

R. W. Hollenhorst, M.D., Mayo Clinic: "Temporal Arteritis"

Walter P. Work, M.D., Ann Arbor: "Cancer of the Larynx"

B. ANESTHESIOLOGY:

Vincent J. Collins, M.D., Chicago (Title later)
George Sutton, M.D., Chicago (Title later)
John W. Severinghaus, M.D., San Francisco: "The Pulmonary Circulation"

C. RADIOLOGY:

David G. Pugh, M.D., Mayo Clinic (Title later)
John A. Evans, M.D., New York City: "Cystic Disease of the Kidneys"

D. SURGERY:

Chester B. McVay, M.D., Yankton, S.D.: "Abdominal Incisions"
(Balance of program papers by members of the Wisconsin Surgical Society. Program details in March JOURNAL)

OUT-OF-STATE GUEST LECTURERS
1962 Annual Meeting

DONALD E. CASSEL, M.D., Chicago
Professor of Pediatrics, University of Chicago Medical School

VINCENT J. COLLINS, M.D., Chicago
Director, Department of Anesthesia, Cook County Hospital

JOHN A. EVANS, M.D., New York City
Professor of Radiology, Cornell University Medical College

LEON GOLDMAN, M.D., Cincinnati
Professor of Dermatology, University of Cincinnati Medical School

ALAN GUTTMACHER, M.D., New York City
Clinical Professor of Obstetrics & Gynecology, Columbia University College of Physicians & Surgeons

R. W. HOLLENHORST, M.D., Rochester, Minnesota
Associate Professor of Ophthalmology, Mayo Foundation Graduate School (Univ. of Minnesota)

ALFRED W. HUMPHRIES, M.D., Cleveland
Associate Professor of Vascular Surgery, Frank E Bunts Institute (Clev.)

ORMAND C. JULIAN, M.D., Chicago
Professor of Surgery, University of Illinois College of Medicine

MAURICE E. LINDEN, M.D., Philadelphia
Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine

ARTHUR M. MASTER, M.D., New York City
Associate Clinical Professor of Medicine, Columbia University College of Physicians & Surgeons

FRED R. McCRUMB, JR., M.D., Baltimore
Director, Division of Infectious Diseases, University of Maryland School of Medicine

CHESTER B. McVAY, M.D., Yankton, S.D.
Clinical Professor of Surgery, University of South Dakota Medical School

ROBERT A. MILLER, M.D., Chicago
Assistant Professor of Pediatrics, Northwestern University School of Medicine

EDMUND R. NOVAK, M.D., Baltimore
Assistant Professor of Obstetrics & Gynecology, Johns Hopkins University School of Medicine

WILLIAM J. OLIVER, M.D., Ann Arbor
Assistant Professor of Pediatrics, University of Michigan Medical School

DAVID G. PUGH, M.D., Rochester, Minnesota
Associate Professor of Radiology, Mayo Foundation Graduate School (University of Minnesota)

RALPH A. REIS, M D., Chicago
Professor of Obstetrics & Gynecology, Northwestern University School of Medicine

ADOLPH ROSTENBERG, JR., M.D., Chicago
Professor of Dermatology and Chairman of the Department of Dermatology, University of Illinois College of Medicine

ROBERT E. SCULLY, M.D., Boston
Assistant Clinical Professor of Pathology, Harvard University School of Medicine

JOHN W. SEVERINGHAUS, M.D., San Francisco
Associate Professor of Anesthesiology, University of California Medical School

GEORGE L. WIED, M.D., Chicago

Assistant Professor of Obstetrics and Gynecology, University of Chicago, Lying-in Hospital

WALTER P. WORK, M.D., Ann Arbor, Michigan
Professor of Otolaryngology, University of Michigan Medical School

JOSEPH M. JANES, M.D., Rochester, Minnesota
Orthopedic Surgeon

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: THE WOMAN'S AUXILIARY TO THE STATE MEDICAL SOCIETY OF WISCONSIN

MILWAUKEE AUDITORIUM . . . MAY 8–10, 1962

Watercolors and Oils Only

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or *his wife* may submit an entry.

LIMITED ENTRIES: Up to 3 pictures per person may be submitted for exhibit.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Doctor and Mrs. William F. Hovis, Jr., Milwaukee, on or before *April 1, 1962. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)*

REQUIREMENTS: (1) All pictures must be framed, with wire and screw eyes attached.

(2) All pictures must be delivered to the Dressing Room on the east side of the Stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 7, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 10.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the two categories will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon. Judge: Edward Dwight, Director of the Milwaukee Art Center.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

Notification of Intent to Exhibit

Mail to Doctor and Mrs. Wm. F. Hovis, Jr.—304 E. Bradley Road, Milwaukee 17, Wisconsin, BEFORE APRIL 1, 1962.

I plan to submit a painting, or paintings, for the 1962 MEDICAL ART SALON at the Milwaukee Auditorium, May 7–10.

My entry, or entries, will be:

(1) Watercolor____ Oil ____ Size ____" wide and ____" deep

(2) Watercolor ____ Oil ____ Size ____" wide and ____" deep

(3) Watercolor ____ Oil ____ Size ____" wide and ____" deep

(1) Title: ____ (2) Title: ____

(3) Title ____

Name: ____

Street: ____

City: ____

the Wisconsin Medical Journal

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Gonadal Dosimetry in Diagnostic Radiology

By DAVID L. MOODY, M. D., JOHN R. CAMERON, Ph. D. and JOHN H. JUHL, M. D.

Madison, Wisconsin

EARLY IN 1896, within 90 days of Roentgen's discovery of x-rays, reports of radiation damage ascribed to experimentation with the new ray were published.[1, 2] Thus, knowledge of the somatic effects of radiation has been available to the scientific community since the inception of roentgen-ray physics. The public was not generally aware of the biologic effects of radiation and relied upon the physician and physicist to provide adequate standards of radiation protection. With the advent of the atomic bomb and the general interest in fallout, the general public has acquired considerable information regarding the results of exposure to radiation. As a result of the emphasis on the genetic effects of this exposure in the 1956 report of the National Research Council, there has been a trend to avoid any or all x-ray exposure. Occasionally this has led to difficulty in obtaining diagnostic examinations on some patients. Accurate knowledge of dose factors in the various types of examination then becomes important in the education and the protection of the patient.

The National Committee on Radiation Protection (NCRP) is a nonfederal advisory board consisting of representatives of the medical societies, x-ray equipment manufacturers, the National Bureau of Standards, and other interested persons. Established in 1946 as a reorganization of a commission begun in 1928, the NCRP issues recommendations concerning radiation protection standards approximately every three years. The recommendations of the NCRP of 1957 included a maximum permissible dose of 14 roentgens (entire body) during the 30-year reproductive life span.[3] Of this amount, an estimated 0.1 roentgen is presently provided by atomic fallout and 3 to 4.5 roentgens by natural environmental sources. Radiation exposures for medical purposes have been estimated to provide 4.6 roentgens additionally.[4] To evaluate this estimate and provide data on individual examinations, a number of investigators have undertaken the measurement of actual radiation dosages on humans and phantoms simulating the human body.[5,6] A wide range of values has been obtained by various observers. It was therefore deemed advisable to determine the range of dosages of each examination at the University Hospitals.

METHODS

A phantom simulating a human figure from the costal margins to the lower thigh above the knees was used for radiological

From the University of Wisconsin Medical School, Department of Radiology.

Doctor Moody's present address is Letterman Army Hospital, San Francisco, California.

Fig. 1—Illustration of experimental arrangement showing phantom with r-meter chamber inserted to measure the radiation at the right ovary. Nate plugs af Mix-D in openings used ta measure ovarian dose in lateral exposures.

measurements (Fig. 1). Within a full body cast of an adult female were placed: (1) lumbar vertebrae, (2) pelvic skeleton including coccyx, and (3) attached femurs. The cavity was then filled with molten Mix-D (tissue equivalent 1.0)[7] and allowed to harden. After removal of the cast, ovarian location was determined from anthropological tables; then holes 1.5 cm. in diameter were drilled from the anterior and lateral aspects of the model intersecting at the desired position for both the left and right ovaries. This was to allow determination of ovarian dosages by insertion of pocket dosimeters at a 90–degree angle to the x-ray beam. The unused hole in the axis of the beam was filled with a 1.5 cm. diameter plug of Mix-D extending from the surface to the ovarian position. That these locations were bilaterally equal was confirmed by simultaneous exposure of dosimeters in these locations. The variations observed were within 4 per cent. All values in Table 1 are those measured directly from the indicated location on the phantom; the radiological techniques are standard voltage techniques used by the Department of Radiology of the University Hospitals. A set of standard exposure values for an individual the size of the phantom was used for each examination.

Dosimeters used in this study included a Landsverk direct reading pocket chamber (Serial No. 23365) and a Victoreen direct reading pocket chamber (Serial No. 1548) for simultaneous measurement of ovarian dosages, and a Victoreen r-meter (Serial No. 453) with 0.25 r and 25 r probes for measurement of skin dosages. The pocket dosimeters were calibrated against the r-meter at 50 MA and with the different kilovoltages used in this study, and the necessary correction factors were obtained. The r-meter had been calibrated by the U.S. Bureau of Standards.

To facilitate this study the standard milliamperage of each examination was converted to 50 MA as a common denominator and the time factor correspondingly adjusted to provide the original MAS* requirement. All other factors including KV, filtration, coning and positioning remained standard for each procedure. Values read directly from the dosimeters were then corrected for calibration, temperature, and pressure before reporting.

RESULTS

The dosages determined in this study are tabulated in Table 1. Included are all examinations for which a gonadal dosage was determinable by our techniques; the procedures not included were considered genetically insignificant because no gonadal radiation could be measured. Intercomparison of these results with those of other authors[5,6] reveals a great disparity in dosage from comparable examinations. This is the result of several variable factors such as KVP, filtration, speed of film and cassettes, and film density requirements. Nevertheless, it is apparent that certain examinations provide greater gonadal exposure than others. This then becomes a consideration in the use of these examinations, particularly in the younger age groups.

As would be expected, the examinations requiring direct exposure of the pelvis result

* Milliampere seconds: time (in seconds) multiplied by the amperage (in milliamperes).

TABLE 1—*Results of examination in which gonadal dose could be measured*
(No measurable doses were obtained from chest photoroentgenograms, routine chest films, skull, mastoids, paranasal sinuses, etc., so they are not included in the table)

Examination	KV	MAS	FFD* In.	Added Filter (MM AL)	Surface Dose in MR	Exit Dose in MR	Male Gonadal Dose in MR	Female Gonadal Dose in MR	Dose Proximal Ovary in MR**	Dose Distal Ovary in MR
Spine: Lumbar										
Anteroposterior	74	125	36	1.5	2500	25	1400	320		
Oblique	76	200	36	1.5	4300	29	730		740	230
Lateral	84	200	36	1.5	6700	36	50		510	86
Cone lateral lumbosacral joint	94	200	36	1.5	8800	13	930		680	96
Barium Enema										
Posteroanterior	110	20	40	1.0	470	9	67	40		
Lateral	110	80	40	1.0	2100	6	46		230	42
Oblique	110	20	40	1.0	560	5	18		90	55
Gastrointestinal Series										
Posteroanterior	110	30	40	1.0	490	8	3	65		
Lateral	110	80	40	1.0	1800	14	5		210	37
Oblique	110	30	40	1.0	560	10	7		120	84
Abdomen										
Anteroposterior	80	15	36	1.5	204	9	7	39		
IVP-K UB										
Kidney, ureter and bladder										
Intravenous Pyelogram	86	20	36	1.5	470	10	150	76		
Pelvis										
Anteroposterior	74	125	36	1.5	2200	14	1800	310		
Coccyx										
Anteroposterior	74	62.5	36	1.5	990	24	860	140		
Hip										
Lateral	78	250	36	1.5	6200	22	120		550	72
Sacrum										
Lateral	84	175	36	1.5	6000	20	170		480	80
Knee										
Posteroanterior and Anteroposterior	72	5	36	1.5	57	1	18	0		
Lateral	74	5	36	1.5	71	0	2	0		
Upper Femur										
Anteroposterior	80	15	36	1.5	220	12	220		32	24
Lateral	90	15	36	1.5	240	10	240		21	15
Lower Femur										
Anteroposterior	75	15	36	1.5	200	10	170	0		
Lateral	80	15	36	1.5	200		175		2	1
Gallbladder										
Caudad Posteroanterior	80	25	36	1.5	260	11	0		23	5
Oblique	80	35	36	1.5	500	9	0	9		
Lateral Decubitus	80	30	36	1.5	410	10	0		16	9

*Focal-film distance in inches.
**Proximal and distal ovarian doses measured in oblique and lateral projections. Note equal doses in anteroposterior projections.

in more gonadal irradiation. With careful coning and positioning, examinations as close to the pelvis as the knee result in essentially no gonadal dose. The effect of positioning is exemplified by comparison of the radiographic dosages (excluding fluoroscopy) received during barium enema with that during a gastrointestinal series. (Table 2).

In this situation, the technical factors including coning are nearly identical, and the skin dosages reflect this similarity. The difference noted in gonadal dosages then is caused by the higher centering of the beam in the gastrointestinal series.

The importance of using high KV techniques is seen by comparing barium enema

TABLE 2—*Comparison of radiographic dosages (excluding fluoroscopy) received during barium enema with that during a gastrointestinal series*

	KV	MAS	FSD	Filter (MM AL)	Surface Dose	Exit Dose	Testis	Ovary
Barium enema PA	110	20	40	1.0	470 mr*	9 mr	67 mr	40 mr
Gastrointestinal series PA	110	30	40	1.0	490 mr	8 mr	3 mr	65 mr

*1 mr = 1 milliroentgen = 1/1000 roentgen.

TABLE 3—*Comparison of barium enema dosages with those from the lumbar spine examination*

	KV	MAS	FSD	Added Filter (MM AL)	Surface Dose	Exit Dose	Testis	Ovary
Barium enema PA	110	20	40	1.0	470 mr	9 mr	67 mr	40 mr
Lumbar spine AP	74	125	36	1.5	2500 mr	25 mr	1400 mr	320 mr

dosages with those from the lumbar spine examination. (Table 3). In these the focal axis and size of the field are identical, but use of a low KV technique necessitates a high MAS to compensate, and results in a high radiation dosage.

DISCUSSION

The genetic consequences of excess radiation have made it imperative for the physician to provide protection for his patient. Studies such as this single out the procedures which are genetically more significant and should be employed only after evaluation of their potential value to the patient. For those physicians who have their own x-ray equipment, an additional emphasis on the value of protective measures is indicated.[8, 9] Careful measurement of diagnostic machine output is important. The use of a cone or lead rubber to shield the gonads from direct irradiation, of high speed film and cassettes, of beam collimation, of filtration to remove useless but harmful "soft" radiation, and of high KV, low MAS techniques, should become standard when possible.[10]

The results tabulated in Table 1 indicate that the examinations of the lumbar spine, lumbosacral joint, and pelvis produce considerably more gonadal exposure than any of the other procedures. It is possible to shield the male gonads quite adequately in these procedures and reduce the exposure to a minimum; this should be done particularly when patients under the age of 30 years are examined. Since the female gonads are in the area of interest in many examinations of the lumbar spine and pelvis, local shielding cannot be used. Whenever the central pelvis does not need to be included, local shielding using lead or lead-rubber can be employed.

Examination of the upper femur results in moderate exposure of male gonads which can also be sharply decreased by a combination of collimation and local shielding. The dosage figures given here were obtained without local gonadal shielding.

The intravenous pyelogram also results in a considerable male gonadal exposure when local shielding is not used. It can be diminished considerably by local shielding. In the examination of the lower urinary tract the female gonads are in the direct beam and are therefore exposed to a moderate amount of radiation. In our department two of the three excretory films are centered over the kidneys with shielding of the lower abdomen. In this way the female gonads are kept out of the direct beam in two of the four exposures used routinely in this examination.

SUMMARY

Measurement of the gonadal dosages delivered during various diagnostic x-ray procedures was undertaken at the Department of Radiology, University of Wisconsin Hospitals. The measurements were made upon a phantom using standard techniques of the Department. The results are discussed in relation to protective measures possible in the techniques of radiography. By knowing the gonadal dosages produced by the various procedures and using care in application of gonadal protection, the medical profession may markedly reduce the increment of the radiation dose provided by medical radiography.

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A Treatment of Pustular Acne Vulgaris A Therapeutic Study

By ERNEST A. STRAKOSCH, M. D., Ph. D.

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THE PURPOSE of this study was to evaluate the combined therapeutic effects of roentgen rays, ultraviolet rays, routine diet, and a sulfonamide, sulfadimethoxine (Madribon), in the treatment of pustular acne vulgaris. The conclusions of previous studies[1-5] were used as baselines for the present study. Crawford, et al.[1] found that 60 to 70 per cent of their patients obtained excellent results with adequate roentgen ray therapy, while Becker[2] observed 60 per cent failures. The value of modern sulfonamides in the management of pustular acne is well established.[3-5] In addition to possessing a high degree of efficacy, they have the advantages of sustained blood levels after small doses, relative freedom from toxic side reactions, and low allergenicity. Drawing extensively from these studies, and as a continuation of a previous study comparing the effects of sulfonamides and various antibiotics,[6] I have attempted to evaluate the combined effects of roentgen rays, ultraviolet rays, diet and sulfadimethoxine in treating pustular acne.

Clinical studies have demonstrated the effectiveness of sulfadimethoxine, a broad-spectrum, long-acting sulfonamide in the treatment of respiratory, urinary tract, and soft tissue infections[7-10] as well as acne vulgaris.[11-13] A low order of toxicity has accompanied the use of sulfadimethoxine in these clinical studies, even on extended use of the drug. Leff[14] administered this sulfonamide to a group of paraplegics for a six-month period with excellent therapeutic results and virtually no toxic reactions during the treatment period. The unique metabolism of sulfadimethoxine may possibly account for its lesser toxicity.[15]

CLINICAL MATERIAL

Eighty patients were studied, 46 of whom were less than 20 years of age, 26 were between 20 and 30 years, and 8 were older than 30 years. There were 49 females and 31 males; and duration of treatment varied from 6 to 17 months. Most patients had received no previous acne therapy except for drying lotions and ultraviolet treatment. Of 6 patients who had previously received sulfamethoxypyridazine, 4 had reactions to that drug and 2 failed to respond.

TREATMENT PROGRAM

All patients were put on a routine acne regimen with elimination of the usual foods contraindicated in acne: chocolate, nuts, and excessive quantities of milk, butter and cheese. They were also instructed to wash affected areas with an antiseborrheic skin cleanser (Acne-Dome Cleanser) followed by application of a medicated cream (Acne Cort-Dome Creme) every evening at bedtime. All other creams and lotions were eliminated and only especially prepared cosmetics for acne were recommended for girls who requested make-up.

A total of 900 r (85 kv. 5 mA.) was given to the areas involved as follows: 75 r once a week for three weeks to forehead and each side of the face, chest, and two to four areas on the back. This was followed during the fourth week by an ultraviolet light treatment to obtain peeling of the skin. This routine was continued until 900 r was given. All pustules were opened and comedones expressed once a week.

Sulfadimethoxine was administered orally to all patients in doses of 500 mg. once-a-day. Initially, patients were given one intensive course of treatment of one month's duration. This was followed by short weekly courses as the case required.

In order to determine bacteriologic and sensitivity patterns, cultures were performed on the first 50 patients before the administration of sulfadimethoxine. Becker and Fredricks[16] office procedure was followed. Organisms cultured included *Staphylococcus albus* var. *aureus* in 48 cases and *Streptococcus* in 2. There were no staphylococci (hemo-

TABLE 1—*Results of Combined Roentgen-Ray and Antibiotic Therapy in 80 Patients with Pustular Acne*

Therapy (Sulfadimethoxine)	No. Patients	RESULTS							
		Temporary (improvement)		Satisfactory (cured?)		No change (failure)		Reactions	
		No.	%	No.	%	No.	%	No.	%
1 long course plus	77							3	4.5
1 to 3 short courses	7	14	17.5	62	77.5	4	5		
3 to 5 short courses	73								
TOTAL	80								

lytic and nonhemolytic) or other organisms resistant to the drug.

COMMENTS

As can be seen in Table 1, one long and three to five short courses of treatment with sulfadimethoxine were necessary in the majority of patients to obtain satisfactory results. The drug had to be temporarily discontinued in 3 patients because severe headache and nausea developed after one week of administration. However, on readministration of the drug two weeks later, no reactions were noted and short courses of treatment were resumed.

Of the 80 patients, 62 (77.5%) had satisfactory results and 14 (17.5%) had temporary improvement. Four patients (5%) did not respond to treatment and were considered failures. On repeat sensitivity cultures of the failures, the only organism cultured was *Staphylococcus aureus;* and it was found that organism resistance had developed in all 4 patients.

It is apparent from this study that sulfadimethoxine is a useful agent in the management of pustular acne. The uniformly satisfactory results, together with the extremely low incidence of untoward reactions, makes it a valuable drug. The need for only one tablet daily provides ease of administration and insures thorough and satisfactory medication. The economy involved in the use of a sulfonamide in comparison with antibiotics is not an inconsequential advantage for the patient who requires long-term therapy.

SUMMARY

The combined therapy of diet, roentgen and ultraviolet rays, and orally administered sulfadimethoxine was studied in a series of 80 patients with pustular acne vulgaris.

Patients were initially given one intensive long course of treatment of one month's duration followed by short weekly courses as the case required. Duration of treatment varied from 6 to 17 months.

Of the 80 patients, 62 (77.5%) had satisfactory results and 14 (17.5%) had temporary improvement. Four patients (5%) were considered failures.

Severe headache and nausea developed in 3 patients after one week of treatment and the drug was temporarily discontinued. On readministration of the drug two weeks later no reactions were noted and treatment was resumed.

From the results of this study—the uniformly satisfactory results and the extremely low incidence of side reactions—it appears that sulfadimethoxine administered in conjunction with roentgen and ultraviolet rays and restricted diet is a particularly valuable regimen for the treatment of acne vulgaris.

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Eye Problems in General Practice

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KNOWLEDGE is available to prevent 75 per cent of all blindness by its chief agents—trauma, disease, and neglect. Ophthalmologists have a duty to perform in disseminating this knowledge to their colleagues in other fields of medicine and to the public. They should lecture and write often on the subject of ocular emergencies. They must be keenly aware of the need of informing not only physicians in other specialties but also general practitioners, in particular, of the importance of the many eye problems that confront every doctor. For the public, they should initiate and participate in educational programs on the prevention of blindness.

The increasing tempo of our lives in an industrialized and mechanized civilization makes inevitable a high and rising rate of ocular injuries. This alone should cause increasing attention to those conditions in the eye that arise from or may be complicated by trauma. Because of the modern tendency of the injured to invoke legal procedure, or at least to submit a number of insurance papers to be filled out, it is extremely important that every eye injury one sees be considered from a medicolegal point of view. This not only offers protection to the patient primarily but also to the physician consulted and to any third party, such as an employer or an outright attacker. Much of the viciousness of the present malpractice situation may be ascribed to carelessness in recording the facts, findings and observations in patients' records. It is easy to say, "Oh, he just has a good old-fashioned black eye," and to be careless in the examination. A jury in court for malpractice may feel differently. Examination and history should be as thorough as time and opportunity permit.

Presented at the 120th annual meeting of the State Medical Society of Wisconsin, May 4, 1961, Milwaukee.

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HISTORY

First, and most important, is a short, concise but detailed history. If injury is claimed, it is important to inquire about the status of the patient's eye prior to the accident. This is a point of prime importance from the medicolegal angle. We are prone to assume that the patient's eyes were normal before injury; whereas we may be dealing with an amblyopic, previously injured, pathologic, or actively diseased eye.

General health is also an important factor to be assessed as early as possible. Diabetes and hypertension as well as other general debilities often are associated with poor vision, but the patient will be inclined to attribute his poor vision to his injury. This should be noted to prevent future controversy.

EQUIPMENT

Every practitioner who examines and treats eyes should have available certain basic equipment. This includes:

1. Some form of vision testing chart
2. A good focal light (floor stand model)
3. Head band loupe for magnification
4. Ophthalmoscope
5. Flashlight
6. Condensing lens
7. Lid retractors
8. Eye spud or blunt needle on 2 cc., or tuberculin syringe
9. Topical anesthetic (0.5% tetracaine hydrochloride [Pontocaine])
10. Irrigating solution (sterile)
11. Toothpick applicators (sterile)
12. Eye pads
13. Fluorescein strips (sterile package)

The most important aid in the examination of an eye is not a flashlight, not an ophthalmoscope, not a slitlamp and corneal microscope, but a visual acuity chart. A visual acuity determination of some sort must be

made—not just of the eye complained of, but of both eyes; and, if glasses are worn, the vision should be determined both with and without glasses. True, it may be inconvenient and time-consuming, but it is important. If the patient can only count fingers or see hand movements, one has reason to be concerned. On the other hand, if he can read 20/20, one is quite relieved.

Edema and slight coloration of the eyelids are most commonly due to an external stye or hordeolum. This is an infection of the glands of an eyelash or of the follicle itself. The abscess usually localizes and drains externally. If a similar lesion is localized in a meibomian gland, an internal hordeolum, or acute chalazion, results. The treatment for either form is hot compresses and a steroid-antimicrobial combination, either as an eye drop or as an ointment to be applied every 1 to 2 hours the first day and then less often until the lesion has either been aborted or localized.

If the external stye does not abort, then when it localizes, it can be incised with a sharp pointed knife and its contents extruded. The chalazion which does not disappear but becomes a localized cyst should be referred to the ophthalmologist.

When the *edema* is due to allergy, the skin of the lids will usually be very crinkly and no tender areas will be noted. Itching is usually present. Ocular allergies respond well to frequent topical applications of steroid drops and/or ointments. However, the occasional allergic lid will prove stubborn and consultation with an allergist or ophthalmologist may be necessary.

THE "RED EYE"

One of the most common complaints associated with a "red eye" is the sensation of a foreign body in the eye. Thus, important consideration should be given to the many patients who come to physicians with a "red eye." Many physicians, seeing a "red eye," think mainly of *conjunctivitis* or *iritis*, but it might just as easily be due to *glaucoma*. The differential diagnosis by the inexperienced can be a very difficult one.

A point I wish to stress is a very simple one, but surprisingly it is seldom mentioned. Take a flashlight and look at the patient's eyes. If the pupils are fairly equal and react readily, the patient is not in serious trouble. In cases of *conjunctivitis*, the pupil will appear normal in size and will compare favorably with the pupil of the other eye as to size and reaction to light. In cases of *iritis*, the pupil will be reduced in size and will not compare favorably with the pupil of the other eye as to size and reaction to light. In *glaucoma*, the pupil is usually dilated and will not compare favorably with that of the other eye as to size and reaction to light. *In other words*, if the pupils are not equal, the patient is probably headed for trouble.

It can be any physician's responsibility to make a diagnosis and to distinguish iritis from glaucoma, but it is the ophthalmologist who is specially trained to treat these diseases. If it is believed that the patient has iritis, the physician should not take the responsibility of instilling atropine into the eye. Atropine might inadvertently be instilled into a glaucomatous eye and produce disastrous results. Nor should any physician be guilty of instilling atropine into a patient's eye following the removal of a topical foreign body and thereby disable the patient for as much as a week. The use of atropine in the eyes should be left to the discretion of the ophthalmologist. It would be well if the atropine solutions and ointments in all general hospitals were to be locked up with the narcotics.

HERPES SIMPLEX KERATITIS

Before closing my discussion of the "red eye," I should like to call attention to an entity I have encountered often in handling industrial eye injuries. The worker believes he has something in his eye and fixes the time of his injury very definitely. A dendritic ulcer of the cornea, which is a virus infection, usually starts acutely with the feeling of a foreign body and is accompanied by photophobia, lacrimation, and pain. The eye is generally quite injected. Careful inspection of the cornea will reveal deviation from its normal smooth, lustrous appearance. When fluorescein is instilled, there can be seen a distinct bifurcating green line which gives off lateral and terminal branches, presenting the form of a dendrite. There is no other corneal picture which resembles this. Therefore, it is pathognomonic. Use of any of the steroid preparations is contraindicated. Since conditions of this sort may be serious, it is best to refer the patient.

FOREIGN BODIES

Recalling the patient with the inflamed, painful "red eye," his discomfort can well be caused by the presence of a foreign body, ulcer, or abrasion of the cornea. All of these conditions are common and fall within the province of any physician not only to diagnose but also in many cases to treat.

The most common eye accident encountered is the retention of a foreign body on the surface of the eye or on the undersurface of the upper lid. The patient is frequently incapacitated as long as it remains. The trauma caused by injudicious and awkward attempts at removal of the foreign body or the introduction of infection may cause damage to vision and even, on occasion, the loss of the eye.

The removal of a foreign body on the surface of the eye is regarded by medical men generally as an event of no great dignity. I should like to change this belief. Because you are a physician, and not because you might happen to be an ophthalmologist, the patient with a cinder in his eye expects you to be able to remove it with the greatest of ease. Unfortunately for the reputation of many, the condition requires a considerable degree of skill in treatment if the particle is to be removed without visual damage and without running considerable risk of complications which may be of grave importance.

To make an adequate preliminary examination it is generally necessary to instill a few drops of 0.5% tetracaine hydrochloride to relieve discomfort and lid spasm. A drop or two of 1:1000 epinephrine serves to enhance the anesthetic effect.

If the foreign body is not on the cornea, be prepared to remove it from the everted upper lid by employing a moistened cotton-wrapped applicator.

Whenever possible, all corneal foreign bodies should be lifted off with a blunt spud in a single maneuver. A sterile hypodermic needle supported on a tuberculin or 2 cc. syringe is a good emergency alternative. In all cases, surgical cleanliness is essential. If the foreign body lies at an appreciable depth, a sharp spud is required. Many types of eye spuds have been devised for this purpose. In all cases, the removal should be purposeful and clean, for repeated attempts at "picking" at a foreign body result in mutilation of the cornea, opening potential avenues of infection and lead to a more pronounced residual opacity.

Many corneal foreign bodies tend to leave rust stains and eschar rings. These are best referred to the ophthalmologist for proper removal, since they can extend the period of discomfort and disability for several days.

Following removal of a corneal foreign body the patient is definitely more comfortable with the eye patched. One should explain to the patient that although he has had a relatively minor injury, it has been necessary to inflict another minor injury in order to remove the foreign body. Corneal epithelium regenerates rapidly but not with the eye open and winking frequently. Patients will accept the bandaging of one eye if the reason for the bandaging is explained. After the foreign body has been removed, the eye should be irrigated, an appropriate ophthalmic ointment instilled, and a moderate pressure dressing applied. A faint area of gray superficial infiltration often persists for several days at the site of removal of the foreign body and causes slight discomfort. In such instances, I prescribe the instillation of a 10% soluton of sodium sulfacetimide in methylcellulose, three to five times a day, for three days.

CORNEAL ABRASIONS

The clinical picture presented by a corneal abrasion is much more alarming than the simple lesion would seem to warrant, owing to the free exposure of the sensory nerve endings and their constant mechanical stimulation by the rubbing of the eyelid over them. The symptoms include acute pain, photophobia and blepharospasm, accompanied by profuse lacrimation in which the other eye participates. Reflex miosis of the pupil occurs, and circumcorneal ciliary congestion usually is present.

The history is usually so typical as to suggest the diagnosis, but a small or even a large abrasion may be difficult to see objectively unless it is brought into evidence by vital staining. The most useful dye for this purpose is fluorescein. The dye leaves the normal corneal and conjunctival surfaces unaltered but stains a damaged cornea brilliant green and the damaged conjunctiva, yellow. In the absence of such a dye, examination of the cornea by oblique focal illumination may reveal irregularities in the cornea.

The prognosis of corneal abrasions is generally good, for a majority can be healed within 24 hours. However, infection can occur. This can result from the traumatic agent, from infection already in the conjunctival sac, from constant wiping of the eyes with dirty fingers or a soiled handkerchief, or from contaminated eye solutions used by the physician who is consulted.

The treatment of uncomplicated corneal erosions is simple. It is best to irrigate the eye well with sterile saline solution. Homatropine can be instilled to overcome the miotic spasm, but the prolonged cycloplegia of atropine is rarely necessary. Antiseptic drops and ointment are then instilled. Most important of all is a firm pressure dressing which should not be disturbed for at least 24 hours to immobilize the lids and prevent their movements from mechanically rubbing off the newly regenerating epithelium. If the abrasion is extensive and occupies a third or more of the cornea, particularly if it involves the pupillary area, binocular bandaging with rest in bed is the most satisfactory procedure. Ophthalmologists recognize the inhibitory effect of anesthetics on epithelial regeneration, and their use is to be discouraged. Antiseptics must be chosen wisely for similar reasons.

OCULAR CONTUSIONS

The old-fashioned "black eye" must not be belittled, at least by the physician consulted. An accurate estimation of the condition of an eye which has undergone contusion often is very difficult to make when the injured eye first is seen because of edema, pain, photophobia and possibly hemorrhage.

In minor contusions of the eye a variety of effects can occur in the various ocular structures, the most important of which are the tears and lacerations of the anterior and posterior uveal tract, hemorrhage, subluxation or dislocation of the lens, and damage of the retina.

Simple cleansing may have to be the only first procedure. If edema is extreme, or if the injury seems severe because of reduced vision and perhaps the presence of blood in the anterior chamber, both eyes should be carefully bandaged, cool compresses applied, and the patient transferred by stretcher and ambulance to an ophthalmologist.

OCULAR BURNS

A most common type of ocular burn in industry is the so-called flash burn of ultraviolet radiation. It also occurs in the use of sun lamps without protecting the eyes. These burns are rarely serious except for the extreme initial discomfort and lid spasm. Such burns are treated with cold compresses, and if necessary, infrequent instillations of topical anesthetic, such as 0.5% tetracaine hydrochloride. Undue use of topical anesthetics may be harmful to the cornea, and for that reason their employment should be minimal.

CHEMICAL BURNS

Chemical burns of the eye present some important problems. There is not only immediate injury, particularly of the cornea and conjunctiva, but also there is a constant, slower and more serious injury of the inner structures of the eye as the chemical penetrates more and more deeply. If a patient is seen soon after acid or alkali has been splashed into the eye, the injury may appear to be very slight. The cornea may appear to be bright, the pupil active and the vision good, but within a short time the cornea may become clouded and intraocular tissues may be affected.

There are few instances in which time is more important than in cases of chemical burns. No effort should be made or time taken to prepare or secure specific neutralizing solutions. Prompt and prolonged irrigation of the eyes with water should be instituted as quickly as possible. Emphasis should be placed on the speed with which this is accomplished. Patients with alkali burns should be sent to an ophthalmologist as quickly as possible, but first-aid irrigation should be done.

WOUNDS OF THE EYELIDS

The general physician is frequently the first to see these wounds, which are common after automobile accidents. The adequacy of the initial treatment frequently determines the final cosmetic result, which is obviously of great importance to the patient.

Before deciding what should be done with any wound involving the skin of the lids, a thorough inspection must be made to determine exactly what structures are involved, whether the wound involves only the skin or

deeper layers of the lid, and whether the globe itself is injured. The possibility of injury to one canaliculus or both canaliculi when the wounds are near the inner angle should be kept in mind.

Wounds around the eyes involve areas richly supplied with blood vessels. Before anything else is done, bleeding must be stopped by compression and application of hot packs, and if large arteries are torn, by picking them up with hemostats and ligating them.

In automobile accidents facial injuries may be only a small part of the total trauma, and the damage to the lids and eyeball may have to wait. If the damage to the lids can be treated immediately, the wounds should be thoroughly irrigated with sterile saline solution and all foreign material removed. Tags of skin should be carefully saved. There is a rich supply of blood in this area and tissue need not be sacrificed as is frequently done in other localities. The ophthalmologist knows the importance of precise repair of wounds of the eyelids, but other physicians who are likely to see the patients first are less likely to be aware of this necessity. There is no need to make immediate repair of such lacerations of the lids that might involve the lid borders, the lacrimal drainage system, or the levator (lid raising) muscle. The closure of these wounds should be left to those experienced in this field, especially to those who possess the instruments and proper suture material for the purpose. In the meantime, sterile antibiotic or sulfonamide ointment and sterile dressings should be applied, antibiotics should be administered parenterally, and tetanus antitoxin or toxoid should be used.

GENERAL TRAUMA AND THE EYES

Injuries to the eye frequently complicate cases of general trauma which crowd the emergency rooms of the hospitals throughout the country, particularly on weekends and holidays. It must be borne in mind that ocular tissues are highly specialized and require excellent attention. Ophthalmologists frequently see cases in which ocular trauma has been neglected because the physician who first saw the patient did not look at the eyes or felt the symptoms warranted no more than casual inspection and gave no thought to treatment. In such instances, an eye or its serviceable vision can be lost because of neglect—all chargeable to the attending physician. One should remember that an injured person is not always capable of revealing every affected part of his body and, quite understandably, one eye when he is still seeing well with the unaffected eye. The degree of shock may be such that a physician is unable to determine how much the patient sees or does not see.

When a physician is confronted with an injured person and discovers that one or both eyes are involved in the accident, he must be able to make decisions, he must know how to proceed to determine the extent of injury, what to do as a matter of initial treatment, and what patients to refer to an ophthalmologist.

There are four important points that a physician must keep in mind whenever he is confronted with an ocular injury:

1. Is the lesion superficial or penetrating?
2. Is the damage such as to interfere with vision?
3. Are complications likely to develop?
4. Has the visual acuity of both the injured and uninjured eye been checked—even though the injury appears very minor—to avoid future embarrassment should legal action ensue?

CHILDRENS' EYES

There are two areas in which the general practitioner often errs in dealing with infants and children. *Atresia of the nasolacrimal duct* is common and is a predisposing factor to dacryocystitis. When the tearing and secreting shows little tendency to resolve, it can be easily cleared away by syringing in some cases, in others by the single passage of a probe. An ophthalmologist should be consulted in these cases.

The problem of *squint* or *"crossed-eyes"* will always be with us. Physicians may try to win the favor of young parents by consoling them with the statement that "Johnnie or Mary might outgrow their squint." Decisions in this field should be left to the ophthalmologist.

When should the infant or child with a crooked pair of eyes be referred to the ophthalmologist? *As soon as the physician or the parents detect the defect!* I highly recommend a *pre-school eye examination* for every child who for no other reason has ever had to be taken to an ophthalmologist.

SUMMARY

Every physician, general practitioners in particular, should be prepared to take care of the common and frequent ocular emergencies that have been enumerated. In the majority of cases of eye injuries, general practitioners and house staff physicians are called upon, more frequently perhaps than ophthalmologists, to render the initial treatment. For medicolegal reasons, I again want to stress the importance of a concise but detailed history and the recording of all pertinent findings, including the vision of both eyes with and without glasses. One must be able to recognize one's limitations and be guided by them. With a sense of propriety, one may remove a foreign body from the upper lid and even from the cornea. Primary abrasions of the cornea or those inflicted by the physician in removing a foreign body must be treated by pressure bandage. The patient should be advised to patch the other eye when he returns to his home. He will be unable to do anything anyway, and this will insure his comfort and rapid recovery.

If contusions are severe or are associated with a reduction of vision, the patient should be referred to an ophthalmologist. Lacerations of the lids which involve only the skin can be repaired by any physician. If they involve the margins of the lids, the canaliculi or the tarsal plates, the patient should be referred.

Blurring or loss of vision and ocular pain, not due to something grossly obvious, should be referred at once to the ophthalmologist, the same as a physician would refer a perforating injury of the globe.

Prudential Plaza, Suite 2419 (1).

TOTAL COLPECTOMY

In the August, 1961, issue of Surgery, Gynecology and Obstetrics, Doctors John I. Perl and the late Nelson M. Percy of Augustana Hospital, Chicago, Illinois, reported on 315 complete vaginal obliterations. Ninety-seven of these patients had had one or more previous gynecologic operations. Two were under 40 years of age and the oldest was 92. The majority of the patients were in the seventh decade. Three patients were nulliparous.

The presenting complaint was usually that of a mass prolapsing through the vulva which made sitting and walking difficult. They also complained of a feeling of fullness, frequency of urination and incontinence of urine, inability to empty the bladder, constipation, spotting or bleeding due to ulceration of the prolapsed part, and backache. Ulcerative cervicitis was common and four of the cervices showed carcinoma. In addition three patients had carcinoma of the body of the uterus, one of the ovary, one Brenner tumor accompanying a carcinoma of the cervix, and one adenocarcinoma of the rectum. Cervical polyps, polypoid hyperplasia of the endometrium, endometrial polyps, endometriosis, and fibromyomas were all commonly found. Thirty of the 315 patients had previously been subjected to total hysterectomy and 17 to supracervical hysterectomy.

In patients of this age group coexisting diseases were prevalent. For example there were 111 cases of cardiovascular disease, 67 of obesity, 10 of diabetes, 16 of nodose goiter, 35 of varicose veins, 16 of hemorrhoids, and a variety of hernias.

There were eight deaths among the 315 patients on whom complete vaginal obliteration was performed. Three of these died from coronary occlusion, three from pulmonary embolism, one from pneumonia after a combined Kraske operation and panhysterocolpectomy, and one elderly patient died on the seventh postoperative day in stupor and with a high temperature. It is interesting to note that the last death occurred in 1945; since then, 106 patients have been subjected to total colpectomy without a death. Urinary and cardiovascular incidents were the most frequent postoperative complications. There were 7 abscesses, 6 adjoining the surgical field.

Of the 315 patients, 307 left the hospital fully recovered with the operative field well healed. The average duration of hospitalization was 26 days. Not a single recurrence was observed or reported by the attending or referring physician among the patients who left the hospital recovered. The authors state that "without qualification, those relieved of the burden of a major genital prolapse by complete vaginal obliteration are the most grateful of patients."

The stages of the procedure consist in: (1) vaginal hysterectomy or excision of the cervical stump, if there has been previous supracervical hysterectomy; (2) excision of enterocele if present; (3) total vaginectomy; (4) repair of cystocele by imbrication of the pubovesicocervical fascia; (5) closure of the peritoneum and suture of the stumps of the cardinal ligaments; (6) suture of levator ani and perineal muscles; and (7) closure of the introitus. Preoperatively the patient is prepared by treatment of the edema with sitz baths, mild antiseptic douches, and bed rest for several days with the prolapsed parts replaced; urinary tract infections are treated; and the operative field is prepared in the usual manner. —V. S. FALK, M.D., Edgerton

Sponsored by Section on Pathology
State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: NORBERT ENZER, M. D.
Milwaukee, Wisconsin

CASE PRESENTATION*

The situation presented involves the problem of identifying the cause of death in a person affected by an illness dominated to a large degree by fever. The details of the case will be presented by Dr. P. Chang, medical resident.

Dr. P. Chang: This patient, a man 69 years of age, had four admissions to this hospital between November, 1959, and November, 1960. On the first admission the complaints were abdominal. He had suffered from constipation for about one week with cramps and irregular abdominal pain, and on the day of admission to the hospital there was a large bowel evacuation with relief of some of the abdominal symptoms. This episode was characterized also by inability to sleep, some abdominal tenderness but no nausea or vomiting, although there was marked anorexia. The history did not indicate any similar episodes in the past, and in general his health had been quite good, although he was known to have had a moderate degree of hypertension and suffered occasionally from dizzy spells and exertional angina with dyspnea. In the long antecedent history typhoid fever was noted to have occurred some 40 years ago, and 20 years ago he had an attack of jaundice. The family history was taken sketchily and only the fact that one sister was diabetic and the mother had been a severe asthmatic was recorded. In the course of the physical examination which in almost all respects was quite within normal limits, he was observed to be free of fever, the pulse rate was not elevated, although there were noted occasional irregularities, confirmed by the observation of ectopic beats heard at the apex of the heart. The blood pressure was 140/90. The examination of the chest disclosed a systolic murmur widely distributed over the precordium; and when questioned about this, the patient apparently had no previous knowledge of this finding. The laboratory examination at this time was limited to only a few items. A moderate leukocytosis was observed with an otherwise normal blood count. A serum amylase test was performed, apparently because of the possibility of pancreatitis, but this was not elevated and the urinalysis was within normal limits. X-ray studies were made of the intestinal tract including the gallbladder, and no abnormal observations were recorded. An electrocardiogram did not reveal any abnormalities except for rather tall peaked T-waves, for which no explanation was given. Proctoscopic examination discovered a polyp five inches above the anorectal junction. This was later removed and found to be benign. The patient was ultimately discharged, having had a completely afebrile course over a period of some days. The abdominal pain had subsided. Bowel movements were restored to normal rhythm, and the entire episode was attributed to fecal impaction. The incidental finding of the rectal polyp was, of course, noted.

The second admission, in July of 1960, was because of a low grade fever presumably present for two or three months. This was associated with night sweats but without chills and a weight loss reputed to have been about 50 lbs. The latter observation was not confirmed, but evidence of a rather steady weight loss for about two years was established. Elicited now was a statement that he and his family had been aware of a yellow color to his skin and a darkened urine for several weeks. Physical examination at this time was not greatly different from that which had been recorded on the first admission, except that now the liver was palpable about 6 cm. below the costal arch, and a flat

*From Mount Sinai Hospital.
Doctor Enzer is Director of Laboratories, Mount Sinai Hospital.

Contributors: P. Chang, M.D., Resident in Medicine, 1959–1961; J. J. Baron, M.D., Associate Pathologist; D. Caine, M.D., Adjunct Physician, Section of Internal Medicine, Mount Sinai Hospital.

x-ray film of the abdomen disclosed enlargement of the liver and spleen. There was some difficulty in evaluating the degree of the fever; but during one week in the hospital, the fever continued with peaks of 102 F. In the laboratory examination there was noted an anemia with a hemoglobin value of 9 gm. per 100 ml., a hematocrit reading of 30% and a leukocyte count of 6,000 with a shift to the left in the differential count. There was a slight degree of retention of sulfobromophthalein sodium, about 8%, and the total serum bilirubin was 1.1 mg. per 100 ml. The cephalin flocculation test was ++++, but serum transaminase was not elevated. Examination of the blood for febrile agglutinins (Salmonella, Brucella) was negative. The record at this time does not indicate any change in the heart murmur nor was there any observation made to indicate the presence of purpura or hematuria. The abdomen was negative for evidences of pain or tenderness or any masses except the palpable liver. X-ray examination of the chest, as on the previous admission, did not disclose any abnormality in the lungs and the contour of the heart had not changed.

On the third admission about two months later, there was noted the complaint of a rash and severe itching, a yellow discoloration of the skin and conjunctivae and a generalized, exfoliative, erythematous dermatitis on the back and abdomen, but more marked on the lower extremities. The liver was enlarged, palpable about 10 cm. below the ribs, not tender, and the edges were smooth. The spleen was not palpable. The remainder of the physical examination was not significantly different from the previously recorded findings. In the laboratory procedures the serum bilirubin was again 1.2 mg. per 100 ml. but the serum transaminase was 147, considerably higher than the first determination. The gamma globulin as noted on the serum protein electrophoretic pattern was slightly increased. The fever continued at about the same level. At this time it is important to note that on the previous admission and at intervals between the second and third admissions and during the third admission several blood cultures were made, all of which were sterile. There was again noted a mild anemia, but no other significant changes were recorded in the blood picture. Under medication the skin condition improved, but the icteric tint persisted and the fever continued. A needle biopsy of the liver failed to reveal any abnormalities. Material obtained at that time was also cultured, and this too failed to provide any organisms.

The fourth admission occurred about two months later, when there was a sudden attack of nocturnal dyspnea with angina. There was mental confusion and the blood pressure dropped to 120/60. Râles were detected in the lungs. There was fluid in the abdominal cavity, the heart appeared to be enlarged, and the rhythm was irregular. Now the anemia was more severe. The total leukocyte count was 15,000, the serum bilirubin was again slightly elevated, and for the first time the blood urea nitrogen was elevated to 80 mg. per 100 ml. An x-ray examination of the chest revealed pulmonary congestion. Measures were instituted to provide relief, but these were without success. On the day of death the patient suddenly was noted to have a right hemiparalysis, became comatose, and died in a few hours.

Throughout the several hospital admissions a precise diagnosis was not established to the satisfaction of those in attendance. On the whole, it was generally felt that an infection was the basis of the disorder, possibly with a major involvement of the liver and that the final episode was an intracerebral hemorrhage, probably on the basis of his hypertensive background.

DISCUSSION

Dr. D. Caine: This patient was a source of trouble from the standpoint of satisfactorily demonstrating an acceptable cause for the clinical picture. A number of conditions were considered at various times in the course of his illness including hepatitis, concealed malignancy with involvement of the liver, leukemia, sepsis of undetermined origin including the possibility of bacterial endocarditis. We were impressed with the prominence of the liver findings in that this organ could account for the mild jaundice, some of the abdominal symptoms, and possibly even provide a background for the febrile manifestations. Conditions such as a hepatitis or subacute cholangitis were considered. At no time was there any detectable evidence of malignancy, and a bone marrow examination failed to support the possibility of a leukemia. The constantly sterile blood cultures further complicated and made difficult the differential diagnosis. The possibility of an endocarditis was entertained from time to

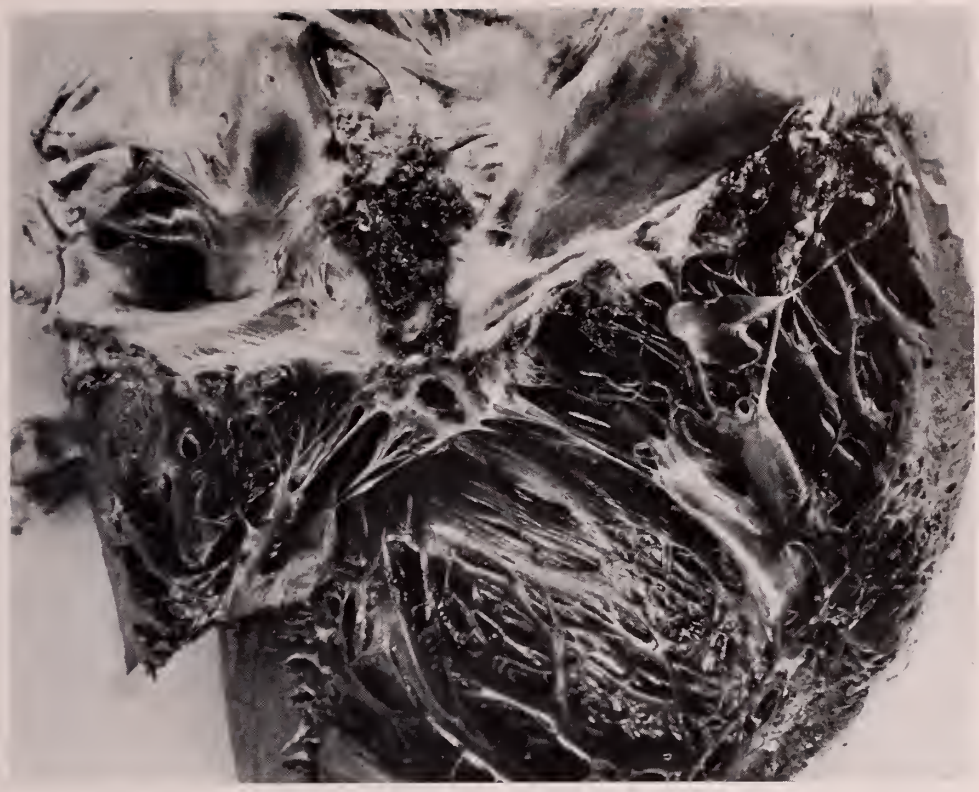

Fig. 1—Opened left ventricle and left atrium showing mitral valve with extensive ulceration, mural thrombus, hemorrhogic vegetations, perforation of onterior leoflet of mitral volve. Alsa note configuratian of papillary muscles which on microscopic exomination estoblish micraobscesses.

time, but it seemed to us and to others that the character of the murmur had not changed throughout the entire period of observation; and there were no manifestations of embolic phenomena.

Dr. J. J. Baron: The postmortem examination disclosed a chronic form of skin disorder with pigmentation and areas of exfoliation and some zones of hemorrhage which were associated with scratch-like markings. The pleural and peritoneal cavities each contained several hundred cubic centimeters of clear straw-colored fluid. The lungs were very heavy, weighing 850 gm. and 1,100 gm. respectively, and presented a diffuse lobular pneumonitis with zones of extreme congestion, generalized hyperemia, and edema. The liver was moderately enlarged (1,580 gm.) and congested but otherwise without gross abnormalities. The spleen was enlarged to about twice its normal weight and diameters and presented, in addition to a diffusely hemorrhagic pulp, several wedge-shaped zones of yellow discoloration. The kidneys were congested and exhibited the so-called "flea-bitten" pattern and several minute yellow foci sharply outlined against the parenchyma (infarcts). In the region of the left temporal and parietal lobes of the brain there was a deeply placed hemorrhage slightly more than 5 cm. in diameter. The heart weighed slightly over 500 gm. and presented a dilated state of all chambers. The important lesion obviously was in the left atrium and mitral valve which, as can be observed in Fig. 1, was involved by an extensive, thrombotic, ulcerative process with erosion of the valve cusps, perforation of the anterior leaflet, and extension of the hemorrhagic and yellow-gray thrombotic material over a considerable zone of the mural endocardium of the left atrium. Except for some atherosclerotic changes involving the aortic ring and the aorta, there were no abnormalities in the other valves. Close scrutiny of the myocardium disclosed several yellow zones in the papillary muscles. The microscopic sections supported the gross findings and established an ulcerating endocarditis of the mitral valve (Fig. 2) and mural endocardium of the left atrium. Bacteria were identified in the sections of the heart valve and myocardium. Other microscopic studies established hemorrhagic bronchopneumonia, an acute splenitis

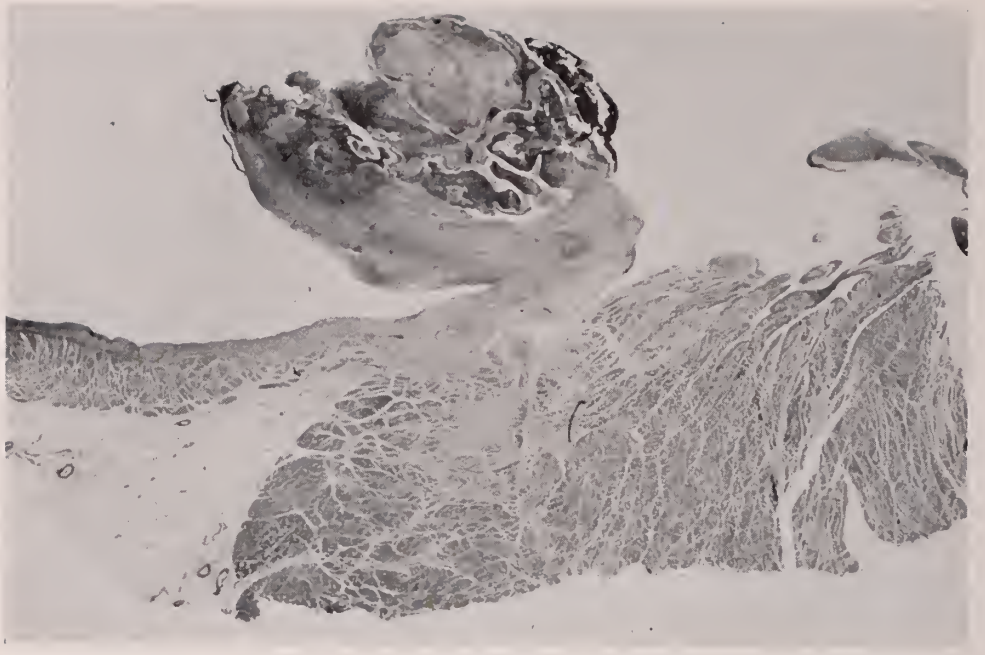

Fig. 2—Low power photograph of section of mitral valve with portion of atrium and left ventricle. Note ulceration with huge vegetations.

with infarction and recent and old embolic glomerular nephritis. The brain sections indicated the effects of the hemorrhage and associated necrosis, interpreted as probably due to local vascular occlusion. Cultures taken from the heart valves produced a scant growth of nonhemolytic streptococci and of coagulase negative staphylococci. The morphology of the organisms as observed in the tissue sections was regarded as compatible with either one or both of these organisms. The final diagnosis from the postmortem examination was *ulcerating, thrombotic, mitral and left atrial endocarditis with septic myocarditis, acute lobular pneumonia, cerebral hemorrhage due to embolic infarction, embolic glomerular nephritis and acute splenitis with multiple infarcts.*

COMMENT

Dr. Norbert Enzer: This case is an example of a condition that we do not frequently encounter. Our hospital files and postmortem material contain a goodly number of these cases which we had in former years, particularly between 1930 and 1940. Also between the years of 1927 and 1930 we had several such cases which in view of the relatively lower hospital population during those years perhaps might be indicative of an increased incidence at that time. Perhaps the infrequency is the result of the introduction of sulfa drugs and antibiotics.

This is a form of endocarditis due to bacterial invasion of the heart which has been variously described as septic endocarditis, acute, thrombotic and ulcerative endocarditis, acute bacterial endocarditis and malignant endocarditis. It is to be distinguished from subacute bacterial endocarditis, which is generally agreed to be based upon a preceding rheumatic endocarditis. The patterns of the two diseases, both clinically and anatomically, are quite different. So far as terminology is concerned, I have favored the adjective "ulcerative" as more appropriate. Suppuration is not always present, but it may occasionally be found in the valves as well as in the myocardium, even to the extent of forming microabscesses in the latter. It is a disease which runs a fairly rapid and virulent course and generally causes death by the generalized effects of a septicemia or the effects of a lethal embolism, such as occurred in this case causing a brain hemorrhage. In contrast to subacute bacterial endocarditis, renal failure, except as a contributing terminal element, rarely is prominent. Very often the disease is part of a generalized infection. This has been observed to be the case where the dominant picture has been an enterocolitis, pneumonitis, thrombophlebitis, mastoiditis, or

sinusitis. The condition therefore may be overlooked during life because of the overriding primary disorder. The difficulties in recognizing the disorder are often due to the absence of a detectable primary infection. In this instance we failed to uncover a primary infection. While it occurred to us that perhaps the skin, because of the dermatitis, may have been the source, we were unable to prove this. This form of endocarditis is often characterized by an absence of evidence of myocardial damage; whereas in rheumatic heart disease and subacute bacterial endocarditis, the total involvement of the heart is a more frequent clinical observation. The invading agent may be any organism, and there has been reported many different organisms recovered during life and at postmortem from the blood or heart. In this case we were hindered by the negative blood cultures for which we were unable to account. While the patient did receive some antibiotics, the amount given was never so large or over so long a time as to warrant the presumption that the therapy was responsible for the failure to recover the organisms from the blood.

One of the interesting features of this type of endocarditis is its occasional localization in the right side of the heart. It is of interest to note that in the event of a right-sided endocarditis, pulmonary involvement may dominate the clinical picture, but by no means always. I would consider that the pneumonitis in this case was indicative of a systemic blood stream invasion.

In this disease, as in the case of subacute bacterial endocarditis, the physician is often led to look to the liver and biliary tract as the site of the disorder causing the complaints. The clinical similarities between subacute bacterial endocarditis and biliary tract and liver infection have been recorded. The presence of a heart murmur is generally very important in the differential diagnosis, yet the absence of a murmur has been experienced. In our case, a murmur although prominent, apparently was not impressive to the clinicians who observed this patient.

From an anatomical point of view this type of endocarditis appears to be more often grafted on an atherosclerotic background in contrast to the subacute bacterial form of endocarditis which is almost always related to a preceding rheumatic endocarditis. In this case the atherosclerotic changes in the infected areas were at best minimal and were disregarded by us in appraising the pathogenesis of the condition. Because of the frequency of association of infection and valvular sclerosis, the age of patients with ulcerative endocarditis is apt to be older than the patient with subacute bacterial endocarditis. The examination of the kidneys revealed the pattern of embolic glomerulonephritis, a condition more common in subacute bacterial endocarditis. The renal pathology is rarely a dominant feature in ulcerative endocarditis; where as it may be in subacute bacterial endocarditis and, indeed, may be the cause of death.

In summary, this case presents a pattern of combined effects; namely, spreading infection, i.e., pneumonitis, renal insufficiency, myocardial failure and embolic phenomena, with persistence to the end of bacterial invasion of the endocardium and myocardium. The clinical and laboratory indications pointing to hepatic disease serve to emphasize the importance of extra-hepatic factors as responsible for signs, symptoms and data usually regarded as hepatogenic. Sterile blood cultures are not proof of the absence of active bacterial growth exposed to the blood stream.

948 North 12th Street (3).

POSTPRANDIAL BLOOD GLUCOSE

KLIMT, C. R. et al.: Calibration of a simplified cortisone glucose tolerance test. *Diabetes* 10:351, September, 1961.

A comparison of 20 diabetics and 116 normals at different test periods of the cortisone-glucose tolerance test showed that the fasting stage used as a screening procedure would have allowed the exclusion of only 13% from the suspicion of diabetes, while at the one hour test period, the proportion which could be excluded had increased to 80%. Thus the contention of the U.S. Public Health Service is confirmed, that the one hour post-glucose (or postprandial) test period is the most efficient period for diabetes screening purposes.

—R. S. BALDWIN, M.D., Marshfield

THE MEDICAL TECHNOLOGIST

The title, Medical Technologist, is explicitly reserved for those who achieve certification by the American Society of Clinical Pathologists and the Registry of Medical Technologists. This is more than a semantic nicety or an artificial status symbol. It is a categorical guarantee of ability and excellence. The Medical Technologist is a well-educated, skilled and ethical member of the medical service team. Beginning in 1962 he or she will be required to have three years of college credit in a difficult curriculum of chemistry, biology and varied liberal arts subjects. In addition, the student must devote one year to training in an approved school of medical technology under the directorship of a pathologist. The student may then take the registry examination. The certification thus achieved is a pedigree of distinction.

This brief discussion of the profession of medical technology has been prepared to increase the physician's appreciation and respect for the individuals who contribute so significantly to the care of his patients. It is also offered as a point of practical information for the physician whose advice is sought by young people exploring the career opportunities in the health professions. It is a service to these students, and it is in the best interest of medicine to recruit and direct desirable people into the profession. Too often medical technology is overlooked by those seeking a career. More unfortunate is the individual with an interest in science or laboratory work who, lacking a competent adviser, responds to the easy appeals of commercial laboratory training courses. He loses time and money, is disillusioned and becomes a problem as he tries to utilize his inadequate training in a field which requires the most exacting work and high standards of ethic.

In addition to the foregoing information which can be presented to interested students, specific details may be obtained from local hospital pathologists, from most colleges and universities which have a curriculum of medical technology, and by writing to the Wisconsin Association of Medical Technologists, Miss Jo Anne Wienke, 1201 E. Singer Circle, Apt. 2, Milwaukee 12, Wisconsin.

—ROBERT L. KASCHT, M.D., Waukesha

APPROVED SCHOOLS OF MEDICAL TECHNOLOGY IN WISCONSIN

Beloit Hospital, Beloit; affiliated with Beloit College.
Sacred Heart Hospital, Eau Claire; Wisconsin State College.
St. Agnes Hospital, Fond du Lac; St. Norbert College, Wisconsin State College.
St. Francis Hospital, La Crosse; Viterbo College, Wisconsin State College, Marquette University.
Madison General Hospital, Madison; La Crosse State College, Stevens Point State College, River Falls State College, Superior State College.
St. Mary's Hospital, Madison; Edgewood College of the Sacred Heart, Mount Mary College, College of St. Teresa, Briar Cliff College.
University Hospitals, Madison; University of Wisconsin.
St. Joseph Hospital, Marshfield; Central State College.
Columbia Hospital, Milwaukee; Marquette University.
Evangelical Deaconess Hospital, Milwaukee; Marquette University.
Milwaukee County Hospital, Milwaukee; Marquette University.
Milwaukee Hospital, Milwaukee; Marquette University.
Misericordia Hospital, Milwaukee.
Mount Sinai Hospital, Milwaukee; Carroll College.
St. Joseph's Hospital, Milwaukee; Marquette University.
St. Luke's Hospital, Milwaukee; Marquette University, Alverno College.
St. Mary's Hospital, Milwaukee; Marquette University, Alverno College.
Mercy Hospital, Oshkosh; Oshkosh State College, St. Norbert's College.
St. Luke's Memorial Hospital, Racine.
St. Mary's Hospital, Racine; Marquette University.
St. Michael's Hospital, Stevens Point; Central State College.
Waukesha Memorial Hospital, Waukesha; Carroll College.
St. Mary's Hospital, Wausau; Wisconsin State College, College of St. Teresa.
Veterans Administration Center, Wood; Marquette University.

A TREATMENT OF PUSTULAR ACNE VULGARIS

(Continued from page 120)

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Approval of Sanitizing Agents

By ROY K. CLARY, R. S.
Madison, Wisconsin

A CONTINUING problem for licensed restaurant operators and others who serve food to groups is the proper sanitization of eating and drinking utensils. Public health agencies have been especially concerned. Manufacturers have not overlooked this interest and in recent years have been offering an ever increasing variety of products claimed to be effective as sanitizers and detergent sanitizers.

Prior to the enactment of the Federal Insecticide, Fungicide, and Rodenticide Act in 1947 no official recognition was given to the use of the words sanitize, sanitizer, sanitizing, and sanitization, although they have been employed for some time in the literature for bactericidal results of various chemical cleaning treatments. The acceptance of this terminology in scientific literature resulted in its widespread adoption in labeling and advertising and made it necessary for various government agencies to give official recognition to these types of products. For example, it was obvious that a manufacturer of a detergent who represented his product as a detergent-sanitizer was making an added claim of practical value.

Among the chemicals offered as sanitizers in Wisconsin are chlorine and chlorine compounds such as hypochlorites. These were found to be effective in destroying microorganisms and used in disinfection as early as 1881 by Koch. The term "available chlorine" is a measurement of the oxidizing power expressed in terms of an equivalent quantity of chlorine. The active germicidal agent of hypochlorites is free hypochlorous acid formed through a hydrolysis reaction with water. This hydrolysis is depressed with increasing alkalinity and lower temperature. The killing of bacteria by hypochlorites seems to consist of two phases: (1) the penetration of the active germicidal principal into the cell, and (2) the chemical combination of this ingredient with the protoplasm of the cell which is directly responsible for the death of the organism.

Chloramine–T, sodium *p*–toluenesulfonchloramide, yields about 25% available chlorine and is quite stable. The chlorine is released much more slowly than in the hypochlorites. A solution of chloramine–T at pH 7.0 containing 250 ppm has been found to provide effective bactericidal treatment in 2 minutes, whereas at pH 8.5, 20 minutes was necessary.

Dichlorocyanuric and trichlorocyanuric acids are organic chlorine-carrying compounds. These chemicals are usually used as an ingredient in detergent sanitizer formulations. Only moisture-free alkalies can be used in these formulations as the presence of water accelerates the rate of loss of available chlorine. The bactericidal efficiency of dichlorocyanuric acid as a sanitizer is comparable to sodium and calcium hypochlorites.

Quaternary ammonium compounds, containing long chain alkyl groups obtained from vegetable or animal fatty acids, are surface-active disinfectants as they have the property of lowering the surface tension of solutions. The inherent features of these compounds which make them desirable as disinfectants are that they contain no phenol, iodine, active chlorine, mercury, or heavy metals. They have no odor, color, are highly stable, and are nontoxic when used as recommended. They are effective against Gram-positive and Gram-negative bacteria that are encountered in general and medical disinfectant practices. The action of quaternaries on bacteria, fungi and viruses results in failure of the treated organisms to grow in certain media or failure of the pathogenic varieties to produce disease. Soaps, calcium and magnesium salts present in water will materially reduce the germicidal activity of quaternaries.

Iodine is a highly reactive element. When iodine acts as a disinfectant, free iodine destroys microorganisms by the formation of salts with proteins by direct halogenation. Iodine is effective over a wide pH range and kills most species of microorganisms rapidly.

Mr. Clary is Director, Hotel and Restaurant Division, Wisconsin State Board of Health.

The combination of iodine and a solubilizing agent or carrier in which the resulting organic combination or complex contains or slowly liberates free iodine when diluted with water is referred to as an iodophor. This is the most common form of iodine sanitizers used in the restaurant field.

The approval of other chemical sanitizers, other than sodium or calcium hypochlorites, used in the sanitization of eating and drinking utensils, was provided for in Section H 96.31 (3) (b) of the Wisconsin Administrative Code which states that other chemical sanitizing solutions may be approved for use by the State Health Officer in which case the concentration will be specified.

In 1958 a program was initiated for analyzing and evaluating other sanitizing agents being sold and used in Wisconsin licensed restaurants. Arrangements were made with the Wisconsin Alumni Research Foundation, Madison, and the National Sanitation Foundation, Ann Arbor, Michigan, to conduct bactericidal tests for the companies manufacturing and distributing sanitizers in Wisconsin. Other laboratories may be subsequently approved by the State Health Officer. This is a voluntary program and the cost of the testing procedure is borne by the manufacturer or distributor. The manufacturer makes financial arrangements directly with one of the two laboratories of his choice. Random samples are selected by representatives of the State Board of Health from unbroken containers at jobbers, distributors, or users of the sanitizers and tested by a standard accepted laboratory test for bactericidal effectiveness.

The laboratory test consists of the Chambers Modification of the Weber & Black Procedure as set forth in the *Journal of the Association of Official Agricultural Chemist* (A.O.A.C.), Volume 41, Number 1, 1958, pages 34–36, inclusive. The complete test provides for the testing of the sanitizer against Escherichia coli and Staphylococcus aureus at both 0 and 500 ppm water hardness and with exposures at both 30 and 60 seconds for each organism. The tests are made in duplicate.

A compound under test is considered satisfactory and approved if it results in a 99.999% kill within 30 seconds in water having a hardness up to 500 ppm. Results are considered satisfactory if the specified effectiveness is obtained against either organism.

Initially, 17 chloramine–T compounds were tested and all failed to pass the Modified Chambers Test for bactericidal effectiveness. Subsequently, two compounds were modified (acidified) and were found to provide a satisfactory kill in the allotted time.

The sanitizer testing program has stimulated a number of the chemical manufacturers to experiment with new sanitizing agents. Manufacturers of sanitizers that are found to have products effective against only one organism are encouraged to improve their formulation so that they obtain an effective kill against both organisms.

A current list of approved sanitizers is sent out at least once a year to all Wisconsin licensed restaurants, members of the Interstate Milk Conference, manufacturers who participated in the program, the Department of Agriculture, and the Regional Office of the Public Health Service. The Staff of the State Board of Health and the health departments which act as agents of the Board under the restaurant program also receive supplemental listings which keep them up to date on all sanitizers that have been approved.

Periodic retesting of all sanitizers other than inorganic hypochlorites is required approximately every two years.

GONADAL DOSIMETRY IN DIAGNOSTIC RADIOLOGY

(Continued from page 118)

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Editors
H. F. HARDMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

INTRODUCTION OF A NEW EDITOR

HAROLD F. HARDMAN, M.D., was appointed chairman of the department of pharmacology at Marquette University School of Medicine on January 1, 1962. He succeeds Harry Beckman, M.D., who has held this position for the previous 35 years.

Doctor Hardman has consented to assume the position of co-editor of the Comments on Treatment page with Doctor Shideman. The Comments on Treatment page has been a regular feature of the Journal since 1938.

Doctor Hardman was born in East Orange, New Jersey in 1927. He attended Bloomfield High School and Rutgers University receiving a B.Sc. degree in pharmacy in 1949. After graduation from Rutgers where he was a scholarship student and member of the varsity basketball team, he served as an assistant in organic chemistry for one semester before entering graduate school. His interests at this time were equally divided between chemistry and biology, so that the decision to study pharmacology under Dr. Carl Pfeiffer at the University of Illinois College of Medicine represented an ideal environment to pursue his divided interests in chemistry and biology. In 1951, he received an M.Sc. degree in pharmacology from Illinois and transferred to the University of Michigan for further work in pharmacology under the direction of Dr. M. H. Seevers. The Ph.D. degree in pharmacology was awarded to him by the University of Michigan in 1954. At that time he was appointed an instructor in the pharmacology department on a part-time basis and devoted his remaining time to the study of medicine. The decision to enter medical school was based upon his opinion that such training would increase his effectiveness as a teacher of medical students and broaden his interests in research. He completed the medical program in 1958 and received the M.D. degree in that year.

H. F. Hardman, M.D.

After graduation from medical school, Doctor Hardman was appointed assistant professor of pharmacology at Michigan and shortly thereafter was awarded a John and Mary Markle Scholarship. This award has been given annually by the Markle Foundation since 1949 to faculty members who represent their respective medical schools from the United States and Canada in competition as promising teachers and research scientists.

In August 1960, Doctor Hardman accepted a position as associate professor of pharmacology at Marquette University. Since then he has served as associate chairman until his current appointment as chairman of the department.

His research interests have been directed toward the cardiovascular system with publications on the effects of drugs upon the coronary circulation, autonomic nervous system, and force of contraction of the heart. In these papers he has emphasized the relationship between the chemical properties of drugs and their pharmacological action. These interests will be reflected in his writings in this column where he hopes to illustrate the importance of basic pharmacological principles in the problems of practical therapeutics.

Doctor Hardman, his wife and four children, live at 1120 Indianwood Drive, Brookfield. The Hardmans are avid followers of the Marquette basketball team and Green Bay Packers. They also enjoy Wisconsin's camping and fishing facilities.

PRESIDENT'S PAGE

We Are Indebted to You

FROM EVERY SECTION of our state, from far and near in Wisconsin, you come with your husbands to the annual meeting of the State Medical Society. The program of your Auxiliary is assessed in reports there; the work to be done by you as an aid to the medical society is planned for the coming year. These tasks your president, Mrs. Howard Johnson, and others are performing in a most creditable manner.

Year after year the same problems concern our profession, and sometimes it seems a lifetime in medical practice will not have solved them.

We are tempted to say, "This is where I came in." One constantly recurring problem is the struggle for the freedom of the medical profession. We become weary and then refreshed when we remember that we are free today because someone worked for this ideal yesterday.

Every day I am fully aware of your weariness in another respect. It is not easy to keep ordered homes when routine is constantly interrupted by the demands of the profession. It is not easy to sublimate your activities to those of your husband's profession. But it is good for him to come home to find you there, to know that the children are properly cared for, that a happy home awaits the end of a long day's work. Your day by day service in your doctor's home is of first importance.

Also of great importance is to be an example to the new doctors' wives who are joining the Auxiliary each year in your true friendship to them and your participation in Auxiliary work. Their joys and sorrows, hopes and problems are similar to yours. Just as your husband will bring home from medical meetings new ideas and books and find inspiration in fellowship, it is my wish that through your participation in the Auxiliary you may also be refreshed by your fellowship and exchange of ideas with which you may sustain the high ideals of the medical profession.

Beyond our immediate family and profession we are deeply involved and affected by the world about us. Today we as a people and nation are confronted by issues that transcend all else. The decisions we and our government make will determine our fate, and most certainly our national destiny, far beyond the mind of man. With the first beachhead of communism now only 90 miles from our shore, we are acutely reminded that time is running out regarding preparation for defense from the horrors of atomic attack. It may well fall on you as women to carry the burden of providing a large part of this defense.

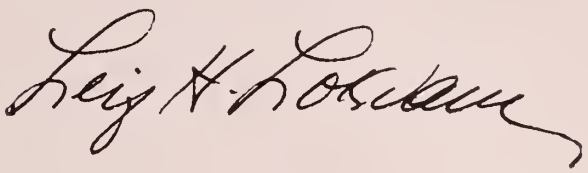
Our nation is also confronted by issues that are not alone concerned with the use or misuse of the hydrogen bomb and atomic energy, the matter of war or threats of war. They concern the day by day problems of human relationship and social responsibility.

A member of a student panel discussion group at the University of Wisconsin is credited with this statement: "It's not *how* we feel about issues, but whether we feel at all." To my mind, this is the heart of the matter —"whether we feel at all."

Surely, as responsible people we must feel strongly about matters of social order and good government. It embraces all facets of organized society including institutions of learning where one may seek the truth without propaganda from any source; the management of civic affairs; law enforcement agencies and courts which serve justice; cultural opportunities and spiritual values. It also includes the humanitarian ministry to the aged, the homeless, the disabled and the sick. The latter is the subject of much attention today in the press and is and has been used as a political football by the prophets of political expediency. This problem is and must be our proper concern. It is not enough

that we, as members of the medical family, glory in doing our routine tasks. This is expected of us. This is our duty.

We must not avoid our additional responsibilities but rather enter into that great and wonderful body described by Ralph Waldo Emerson as the "Society of the Concerned." We must not only be deeply concerned over the problems of the aged, but of all ages. We must not only be concerned over what is the present image of the doctor and doctors' wives, but also what is creating that image for good or evil. The true meaning of the word "auxiliary" is to confer aid and support. This aid and support you freely give to the physicians and the medical society. We are all indebted to you for all that you do patiently day by day.



PREPARATION OF MANUSCRIPTS FOR WISCONSIN MEDICAL JOURNAL

Exclusive Publication: Articles are accepted for publication on condition that they are contributed solely to this Journal. Publication elsewhere will be subsequently authorized in the discretion of the Medical Editor.

Correspondence: Address all correspondence relating to publication of scientific papers to the Medical Editor.

Manuscript: Type double spaced, on 20 pound white paper, 8½ by 11, with one-inch margins at the top, bottom, and right, and 1½ inches on the left. Submit the original and two carbon copies. Use the metric system throughout. Call drugs by their generic names. The trade names can be added, in parenthesis, if they are considered important. Keep one copy of the paper.

Identification: Place the name of author and page number at the upper left-hand corner of each page except the first.

Footnotes and References: Use the style of the *Index Medicus* published monthly by the National Library of Medicine, which requires, in the order given: name of author, title of article, name of periodical, with volume, pages, month—day of month if weekly—and year as follows:

4. Doe, J. E.: What I Know About It,
Wisconsin Med. J. 54:717–719 (Dec.) 1954.

And, include only those references specifically referred to in the text. References will not be published with the article, but will be available upon request to the Journal.

Reprints: An order slip for reprints with a table covering cost will be sent with the galley proof to each contributor.

Illustrations: Four illustrations per article are allowed without cost to the author. Beyond this number the author must pay the actual cost of illustrations. Place the name of the author on the back of each illustration, table, etc. Submit clear and distinct 3 by 5 glossy photographs. Make drawings in black ink on white paper. Attach a slip of paper to the bottom of the illustration with the author's name, identification of article, and appropriate legend. Photographs and drawings will be returned if so requested.

Under ordinary circumstances articles are scheduled about six months in advance. The approximate date of publication, subject to change, will be given the contributor when the article has been accepted.

Society members throughout the state are encouraged to write up their interesting cases and submit them for publication. The editorial staff welcomes the opportunity of helping you prepare your article for the printer.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Double End Play

ANYONE WHO HAD been seduced by the apparent sincerity of the proponents of tax-supported medicine may have gotten a nasty shock from two recent developments that exposed their real motives. Although unrelated, the two episodes point conclusively to the fact that tax-supported medicine as an issue is a coin of greater value to those who propose it than to those who may receive it.

First, Blue Cross and the American Hospital Association, in a two-day meeting in Chicago, went on record as opposing the King-Anderson Bill that would link medical care for the aged to Social Security in a federally administered program. Instead, said Blue Cross, the government should give aged people who cannot pay their health bills a Blue Cross policy, paying the premium in part or in full, depending on the financial condition of the beneficiary. Of course, Congress would have to find the money for the premiums.

How obviously nice for Blue Cross. Millions of new policies without any selling expense, virtually a guaranteed income with practically no risk of losses exceeding income, and a solid underpinning for Blue Cross's possibly shaky fiscal establishment. It escapes Blue Cross that if the government subsidizes, it has a perfect right to control. Blue Cross has invited government subsidy for medical care, the very thing organized medicine and all thinking opponents of tax-supported medicine are struggling to prevent. Blue Cross, let it be noted, is not proposing government subsidy of *any* insurance for the aged; it is proposing government subsidy of Blue Cross insurance only. Blue Cross is thus saying that it favors pie-in-the-sky provided that Blue Cross bakes and sells the pie.

At the same time that Blue Cross's proposals were making the news, word came that John M. Bailey, national chairman of the Democratic party, had selected medical care for the aged as the "most attractive" issue of the 1962 elections. This thinking, not too oddly, coincides with that of Secretary of Health, Education and Welfare, Abraham A. Ribicoff, who reported to President Kennedy on December 7 that the administration's program for medical care tied to the Social Security mechanism was "the hottest item in the Democrats' political storehouse" and "the greatest sleeper in the 1962 political situation."

Notice that the Democratic strategists are playing it cool on civil rights, nor are the party leaders too exercised about a general aid bill for school construction and payment of teachers' salaries, which will have a lasting effect on the kind of citizens we will have in the future. These aren't glamorous issues to an estimated seventeen million voters over age 65 and their sons and daughters. The fact that passage of King-Anderson type legislation carries with it automatic tax increases that haven't yet been fully explained doesn't deter the Democratic party leaders from plunging on with this legislation. It means nothing to them that tax-supported medicine not only spells the end of American medical care as we know it today but also adds immeasurably to the tax burden on this and future generations of Americans—they must support a medical care program that compels the participation of millions who are already protected by private plans of their own choice.

Like the Blue Cross proposals, the primary consideration in the Democratic party's drive for passage of King-Anderson type legislation isn't to provide effective medical care with dignity and humanity in time of emergency. As Blue Cross's proposals are designed to perpetuate its organization, the Democrats' program is planned to solidify its power by roping in a very large block of voters whose citizenship is blind beyond their own immediate personal advantage.

Tax-supported medicine may be clothed in resplendent outer garments of humanitarianism and social progressivism. But they poorly conceal the shabby underclothing of cynical selfservice. —D. N. G.

Motherhood Enhanced

IN THE FARDEL of great questions and burning issues, the quietly selfless work of dedicated physicians on the less dramatic aspects of medicine is liable to go unnoticed. A good case in point is the work of the Maternal Mortality Study Committee of the State Medical Society, which has carefully evaluated every maternal death occurring in Wisconsin in the last seven years. It has done a superb job of informing doctors and hospital personnel on current problems connected with obstetrics.

Meeting on the average of four times a year, members of the Study have given generously of their time and efforts in an important project. When an instance of maternal mortality occurs, trained interviewers meet with the attending physician to review the circumstances of the death. By enlisting the cooperation of the attending physician, the interviewers carefully avoid the flavor of an investigation; in fact, all cases are coded and identifying features removed before the information is transmitted to a group of ten physicians for study.

From the work of the group have come many benefits to the practice of medicine, as well as to the general public. While special problems are described in the Wisconsin Medical Journal, the Study has since 1958 conducted 13 interpretive teaching conferences attended by a total of 1,420 physicians and hospital personnel. Special bulletins have also been dispatched to hospitals spotlighting the findings of the Study.

So important is the work of the Maternal Mortality Study and its teaching program that the Wisconsin Academy of General Practice has devoted portions of its scientific program to it and several of its conferences have been sponsored jointly with WAGP chapters.

Members of the State Medical Society can be proud of the work done by the Maternal Mortality Study group, and the doctors who have given so generously of their talents and time to this project can justly feel great satisfaction in performing a vital service to their profession and to their community. —D. N. G.

Common Grounds for Cooperation

DURING RECENT years there have been many areas of tension between hospitals and the medical profession. The operation of insurance programs and the question of whether certain specialties are to be rendered as hospital services, among others, have created a public image that hospitals and physicians are competitive and are pulling in opposite directions.

It is gratifying to note that in the direct care of the patient there remains the closest of cooperation. The State Medical Society, in cooperation with the Wisconsin State Board of Health, has conducted a number of teaching programs—with physicians and hospitals participating in the areas of maternal deaths, care of the newborn, and prematurity institutes. At each of these conferences emphasis is placed upon *cooperative effort* on the part of physicians and hospitals. The State Medical Society and the State Board of Health are to be commended for initiating and financing these teaching programs, and the hospitals are likewise to be complimented on their cooperation in sending representatives and publicizing the programs.

There are many common grounds of cooperation between these three groups, and it is gratifying to note that programs of this kind are being developed in Wisconsin.

New Light

THE GREAT radiation scare has surged and ebbed with such regularity since the advent of the nuclear age that the strange spectacle of emotional coloration is sometimes apparent in an area that ought to be frigidly scientific. Too often extremist attitudes are perceptible, ranging from the abreaction of an anxious reader of the Sunday supplements to the derring-do of the swash-buckling, bare-handed fluoroscopist.

The need for precise information about permissible doses of body radiation together with knowledge of the factors governing their production is vital. Moody, Cameron and Juhl help to meet that need in their splendid article in this issue of the *Journal.* "Gonadal Dosimetry in Diagnostic Radiology." By use of an ingenious method they were able to record the number of millioroentgens incurred by the ovaries and testes during a variety of radiographic procedures with standard techniques.

Their study delineates the examinations that demand the utmost consideration for the protection of the patient, and clearly illuminates those whose value must be weighed on the scale of ionizing radiation. The need for constant vigilance by the radiologist is pointed up, for it is his responsibility that high kilovolt-low milliampere second techniques are employed wherever possible, that his equipment is always properly calibrated, and that there is no neglect of appropriate use of the shield and collimator.

—D.N.G.

Vitamin D Milk Today . . . A LETTER AND REPRINT

TO SMS:

Since I received your letter I have kept in mind your suggestion that I make comment or contributions that seem to be pertinent from time to time. Up until now I did not feel as though I had any significant comment to make that was appropriate for the Forum; however, I am attaching copies of an editorial from the *Journal of Milk and Food Technology,* October 1961, Vol. 24, No. 10, page 303. It is entitled, "Vitamin D Milk Today," written by one of the best authorities in the country, Dr. Franklin C. Bing. Dr. Bing for many years, was Secretary of the Council on Foods and Nutrition of the American Medical Association and has an excellent background in the field of nutrition and public health.

A few years ago the Council on Foods and Nutrition gave the dairy industry credit for eliminating rickets as a nutritional deficiency through vitamin D milk. However, we now observe that in many localities, dairies are not adding vitamin D to homogenized milk, and in many sections of the country rickets is reappearing. As a matter of fact, right here in our own state of Wisconsin we have had such reports.

Should you have comment or question, I would be glad to have you call me.

HENRY T. SCOTT
Director Biological Laboratory
Wisconsin Alumni Research Foundation
506 North Walnut Street
Madison, Wisconsin

In 1955, the Council on Foods and Nutrition of the American Medical Association, with regret, announced that it no longer would accept individual brands of foods. The Council then reviewed the status of vitamin D milk. It was estimated that about 90 per cent of the fluid milk supply was being fortified

with vitamin D, whereas twelve years earlier, only about ten per cent had been fortified. Coincident with the tremendous increase in the extent of fortification, there had been a gradual disappearance of rickets among infants and small children in areas where this deficiency disease had continued to exist through the 1940's. "A modern miracle" is what the Council called the final conquest of this once common condition. The accomplishment was attributed in large degree to the efficient manner in which the dairy industry was fortifying nearly all its fluid milk. The Council urged that the program be continued, even though circumstances prevented the further use of the Council's seal on labels and in advertising.

What has happened in the intervening years? The industry now is on its own. What are the problems it has encountered, and how has it solved them during the last several years? On this eve of the 30th anniversary of the vitamin D milk program, it is appropriate to take stock.

Although the vitamin D milk program was guided and supported by the A.M.A. Council for many years, it has always been a voluntary program, undertaken by the dairy industry in the interests of better health. Whereas enrichment of flour and bread are compulsory in about half the states, no law requires the addition of vitamin D to milk. The only way that consumers can know that vitamin D is in the milk they purchase is by reading the labels, and consumers do not read labels; at least they do not read them regularly, and with understanding. The responsibility for continuation of this health program thus rests almost entirely upon company management.

Today, as far as can be determined, it appears that the extent of fortification of milk with vitamin D is holding up very well indeed. The present situation is testimony of the awareness by executives of the dairy industry of the importance of vitamin D milk, especially for infants, small children, and their mothers. The continued efficient handling of this program represents an achievement for which the dairy industry may well be proud, and for which the American public can be truly grateful. There have been some obstacles, however, and mention of some of them may help in their solution, should they arise again.

There have been, for example, two new types of preparations offered to dairies in the recent past for the fortification of milk, both of which proved to be unsatisfactory. One preparation consisted of vitamin D dissolved in an oil, but it lacked an emulsifying agent. The resulting unequal distribution of the vitamin D produced a fortified milk of variable potency. This particular preparation was also packaged in a pressurized can, which bore directions that would not encourage careful measurement of the concentrate. The other preparation consisted of a wafer, which contained vitamin D; it lost potency on storage before it could be used. The suppliers of these preparations had reports of assays, made on the freshly prepared concentrates, to show to potential customers, but they had no reports of assays of vitamin D milk made with their products under commercial conditions. Such reports were obtained in due course by dairies which used one or the other of these preparations. It is likely that in the future dairies will demand proof of performance before they change their methods of incorporating vitamin D into products for which they alone are responsible.

The industry is beset not only by some ingredient suppliers, but at times by some of its important customers. In two major cities not long ago physicians were surprised to find some cases of moderate rickets among infants admitted to hospital wards. Inquiry revealed that one or two supermarkets had insisted that ordinary milk be supplied to their stores in place of vitamin D milk. There can be no doubt that the stores were able to secure a slightly lower cost-price on milk under such a stipulation. The trend toward a greater distribution of milk through stores, with fewer home deliveries, means that more business executives are involved in the decision as to whether or not the public is to get vitamin D milk. Fortunately, from the health point of view, the instances mentioned appear to have been exceptional, isolated cases.

The fruits of the vitamin D milk program can be seen everywhere in the straight backs, sturdy legs and well-shaped heads of little children. They can be seen in the admirable physiques of tall, well developed young men and women in high schools and colleges, and in the military services. Other preparations of vitamin D, and other health measures, have contributed to this harvest of good health, but vitamin D milk in large measure has assured the benefits of adequate vitamin D intake to virtually all children.

Except with occasional cases of refractory rickets, and other rare anomalies, professors of pediatrics today can no longer step into a hospital's children's ward and show medical students the rachitic rosary, craniotabes, bowed-legs, and the deformed pelvic bones of rickets, or the carpopedal spasms and tetany which once were associated with inadequate therapy of rickets. Occasionally, physicians may encounter cases of overdosage of vitamin D, or see patients with idiopathic hypercalcemia with failure to thrive, or patients with hypercalciuria accompanied by stones of the urinary tract. But these medical conditions are relatively uncommon in this country. If vitamin D is involved in their etiology, the dosages with which they are associated are greater than those which can be secured with the use of vitamin D milk.

The industry leaders who have participated in the planning, early struggles, and continued cultivation of the vitamin D milk program, the benefits of which are enjoyed by all Americans today, unfortunately are becoming fewer in number, as time takes its toll. They are being succeeded by younger men, many of whom have never heard of rickets, or seen bow-legged children. There is a need, therefore, for continued efforts to make certain that there shall always exist an awareness that vitamin D milk is important for the continued health and strength of the nation.

Franklin C. Bing, Ph.D.
30 North La Salle Street
Chicago 2, Illinois

WILLIAM D. STOVALL, M. D.

More tributes to a dedicated man of medicine

From LESLIE H. FISHEL, JR., Madison
Director, State Historical Society of Wisconsin

I have just had an opportunity to read the *festschrift* to Dr. Stovall in the October, 1961, issue of the Journal. It is a wonderful tribute to a wonderful person and you (Dr. D. N. Goldstein) and the Journal deserve the thanks of non-medical people as well as medical people for your generous allocation of space and praise. Dr. Stovall's contributions to Wisconsin match his constructive efforts in behalf of the health of mankind.

Space did not permit you to mention all of the activities which have taken up Dr. Stovall's time, but I know that you are familiar with his work as President of the Medical Society's Foundation and particularly his instrumental role in making the Museum of Medical Progress in Prairie du Chien a reality. Dr. Stovall was one of a few doctors and laymen who caught the spirit and the meaning of the Medical Museum long before it came into existence, and his dedication to this purpose never flagged.

Dr. Stovall's interest in medical history overlapped into other forms of history. Since 1958 he has been a member of the Board of Curators of the State Historical Society and, as in his other pursuits, he has taken his responsibilities seriously. He has made valued contributions to the Society in meetings, on committees, and in dozens of informal discussions.

On behalf of the State Historical Society, I congratulate you on your fine tribute to Dr. Stovall.

From EDWARD J. McCORMICK, M. D., Toledo, Ohio
Past President, American Medical Association

I have read with a great deal of interest the October, 1961, issue of the *Wisconsin Medical Journal* which has been dedicated to Dr. Stovall.

I did not know until I read the Journal that Dr. W. D. Stovall had been so signally honored by his medical society and I would have been pleased to have written my own thoughts about Dr. Stovall in the last issue of your Journal had the opportunity presented.

I have always admired Dr. Stovall and have known of his work for many years. It has been a pleasure to meet him and to work with him in the American Medical Association. I have always felt he was an outstanding medical man because his work and his devotion have reached to the national level where he is well known. He has made a great contribution to medicine and to the people of this country. I hope that when you have the opportunity you will convey to him my congratulations and my sincere regards, and I have a feeling that additional honors will come his way in the not too distant future.

From MRS. KONRAD C. TESTWUIDE, Sheboygan
Active Participant in Wisconsin's Cancer Program

Thank you for sending me the October issue (1961) of the Wisconsin Medical Journal which contains a Festschrift dedicated to Dr. William D. Stovall. You (Dr. R. S. Baldwin) and your staff and Editorial Board are to be congratulated upon this wonderful edition. I know that Dr. Stovall was very much pleased by the action of the Editorial Board in deciding to do this. I was pleased for the topic you gave my article.

From HAROLD S. DIEHL, M. D., New York City
Senior Vice President for Research and Medical Affairs and Deputy Executive Vice President, American Cancer Society

I am thrilled to receive a copy of the October issue (1961) of the Wisconsin Medical Journal. This is a wonderful and thoroughly deserved tribute to your (Dr. W. D. Stovall) many magnificent achievements in the field of medical education, medical service, public health, medical organizations and community services—national as well as local. I am immensely pleased to have this as a keepsake and memento of our friendship which I shall always cherish dearly.

From GEORGE F. CRIKELAIR, M. D., New York City
Former Student and Personal Friend

My congratulations on the journal which you have recently edited on honoring Dr. Stovall. May I extend my congratulations to you and your entire staff for so nicely recognizing such a wonderful man.

From WARREN H. SOUTHWORTH, Dr. P. H., Madison
Professor of Health Education, University of Wisconsin

I saw an announcement somewhere that the October issue (1961) of the State Medical Journal was devoted to the life and work of our beloved Dr. Stovall. I greatly admire Dr. Stovall, and I would greatly appreciate having a copy of the Stovall issue of the Journal.

From WALLACE MARSHALL, M. D., Florala, Alabama
Formerly of Watertown, Wisconsin

Your Festschrift in honor of famed W. D. Stovall, M.D. is a work of art! Kindly accept my congratulations and thanks for voicing the feelings of gratitude for a remarkable colleague by the name of W. D. Stovall, M.D. You have just cause to be very proud of this beautiful editorial work you have accomplished!

THE MEDICAL FORUM

Physicians Play Major Role In New State CD Medical Self-Help Training Program

News Briefs

SPEEDUP IN PAYMENT

The Veterans Administration is speeding up payments to private physicians participating in the agency's home-town medical program for treatment of veterans with service-connected conditions.

Time required for payment will be reduced to 15 days or less in some instances by automatic data processing.

Some 2,327 State Medical Society members participate in the home-town program.

WPS ADDS TO RESERVES

Wisconsin Physicians Service, the health care plan of the State Medical Society, added $106,438 to its reserves during November, 1961, according to Herman L. Toser, insurance director for the Society.

This results in a total of $501,215 added to reserves during the first 11 months of 1961, Toser said.

SUMMER CAMP FOR DIABETICS

The summer camp for diabetic children will be conducted for the fourteenth year under the auspices of the Chicago Diabetes Association from July 15 through August 5, at Holiday Home, Lake Geneva, Wisconsin.

Boys and girls from 8 through 14 years of age are eligible.

Rates for summer camp are arranged in accordance with individual circumstances. Applications may be obtained from: Chicago Diabetes Association, 620 North Michigan Avenue, Chicago 11, Illinois.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician in addition to the regular staff.

A medical self-help training program, designed to give families the knowledge and skills to take care of their own health needs in time of national emergency, is being organized in Wisconsin, with some phases of the program already underway.

The program was designed by the Public Health Service in cooperation with the American Medical Association's Council on National Security and Committee on Disaster Medical Care. It has been endorsed by the State Medical Society of Wisconsin and the American Medical Association.

County medical societies and individual physicians are urged to cooperate in their own communities by offering guidance and serving as instructors in the courses.

The present program is a pilot effort, to be conducted in 80 localities in the state. It is expected that eventually this will be expanded with the ultimate goal of training one member of each family in Wisconsin in medical self-help.

The course will be offered in a series of 12 lessons, to be taught in eight two-hour sessions. It includes subjects such as:

1. Radioactive Fallout and Shelter
2. Hygiene, Sanitation, and Vermin Control
3. Water and Food
4. Shock
5. Bleeding and Bandaging
6. Artificial Respiration
7. Fractures and Splinting
8. Transportation of the Injured
9. Burns
10. Nursing Care of the Sick and Injured
11. Infant and Child Care
12. Emergency Childbirth

A state plan for implementation of the program has been devised by a committee composed of representatives of the State Board of Health, State Department of Public Instruction, State Medical Society and State Bureau of Civil Defense. Also participating were representatives of the Board of Vocational and Adult Education and Agriculture Extension Service.

For the pilot program, the courses will be organized through the local units of the Vocational and Adult Education system, Agriculture Extension Service, Civil Defense organization and Public Schools. Each will be in a preselected locality to give a representative enrollment by type of student and area of the state.

The course is taught by means of a specially designed kit, including an instructor's guide which gives the word-for-word lectures on each topic, study guides for the students, and such additional materials as a slide projector and colored slides to demonstrate the lessons.

(Continued on page 144)

ANNUAL MEETING FEATURES

Two special features of the 1962 Annual Meeting of the State Medical Society include programs on athletic injuries and closed chest cardiac massage.

For full details see page 150 of this issue of the Forum.

The Annual Meeting will be held May 8, 9 and 10 in Milwaukee. An outline of the full program is printed elsewhere in this issue of the *Wisconsin Medical Journal.*

School Health Council Views Physical Fitness

The role of schools and communities in tackling the problem of physical fitness was examined February 2 at a meeting of the State School Health Council, held in Milwaukee.

The council is composed of representatives of 35 state organizations interested in promoting better health among all children and youth of school age in Wisconsin. Dr. L. M. Simonson, Sheboygan, is the State Medical Society's representative.

As a measurement of the present status of youth fitness, Charles Nader, of Marquette University's department of physical education, reported that in recent tests at the university involving 535 freshman students, 200 were average or above in each of six test exercises. The remainder were below average in one or more categories.

Lynn Jordan, supervisor of physical education at West Allis, outlined that school's efforts to promote tension control as part of the physical education program.

"With increased interest in the subject and its inclusion in several college curricula, tension control may soon assume equal importance with nutrition, physical exercise and weight control in the maintenance and improvement of health," Jordan stated.

Dr. James P. Conway, Shorewood Health Officer, told the council that school health is only a part of the overall problem of community health. He stressed that the basis of good community health must be focused on the family, from the newborn to the older adult.

Frank Stangel, of the Milwaukee Public Schools, explained how that city is attempting to achieve health education objectives with emphasis on courses for teachers and parents.

During the afternoon session Adeline Levin, Milwaukee Public Schools, explained effective organization of school health programs and various materials available were exhibited by Mrs. Ellen McComb, director of Audio-Visual Aids, Milwaukee Public Museum, Miss Emma Diekroeger, director of the Curriculum Library, University of Wisconsin–Milwaukee, and Robert Van Raalte of the State Department of Public Instruction.

Available Publications on Civil Defense

The following pamphlets, of use to the general public for Civil Defense planning, are available from your city or county Civil Defense director. If he does not have them on hand, he may order them cost free from the State Civil Defense Office:

"First Aid"—(L–2–12)—giving basic first aid instructions and listing the recommended first aid items to be stored in a family fallout shelter area.

"The Family Fallout Shelter"—(MP–15)—explaining the need for shelters, how to live in them, and giving basic plans for constructing various types of shelters.

"Individual and Family Preparedness"—(NP–2–1)—outlining the steps a family can take to prepare for a disaster and giving a recommended food supply to be maintained in the shelter area.

"Home Protection Exercises"—(MP–1)—lists eight exercises a family can perform in such areas as preparation of a shelter, fire prevention and fire fighting, emergency action, provision of safe food and water, and home nursing. Assigns individual family members to duties.

(If supplies of these pamphlets are not available through your local Civil Defense organizations, contact the State Medical Society, Box 1109, Madison, Wisconsin.)

Plan Medical Self-Help CD Program

(Continued from page 143)

Nonmedical instructors will be required to adhere strictly to the lesson format in the kit; physician instructors will not.

While it is desirable to have physicians or paramedical personnel doing the instructing, nonmedical persons with understanding of the material, an intense interest in the subject, and speaking or educational experience will also be utilized.

The local administrators of the course will be responsible for providing instructors and County Medical societies and individual physicians are encouraged to cooperate fully with them in filling requests for instructors, according to the Committee on Disaster Medical Care of the State Medical Society.

This committee, and its chairman Dr. John S. Wier, Fond du Lac, have been working closely with the Civil Defense organization in implementing the program. Members are Dr. E. A. Bachhuber, Milwaukee; Dr. S. J. Graiewski, Oshkosh; Dr. D. L. Williams, Madison; and Dr. Harold Cook, Milwaukee.

UW Trust To Provide Medical Student Loans

Approximately $28,000 per year will be available for loan to young men who need assistance in financing their premedical or medical education at the University of Wisconsin as the result of a trust fund recently presented to the university.

The fund, amounting to $1,300,000, was donated to the university by Capt. John Darwin Manchester, an alumnus who was one of the pioneers in the development of the modern Navy Medical Corps.

The $28,000 is the estimated annual earnings which will be available for loans.

The late Captain Manchester was a native of Waupaca and attended the University of Wisconsin, later transferring to Rush Medical College in Chicago where he received his medical degree in 1899. Wisconsin had no medical school at that time.

The will provides that the university create the John Darwin Manchester Endowment Fund to be used "to loan funds, with or without interest, as the university may deem proper, to young men students whom it shall deem to be desirable students and deserving and in need of financial assistance in securing premedical and medical education."

SMS Subcommittee Discusses Factors In Laws On Commitment

The Subcommittee on Commitment Laws of the Division on Nervous and Mental Diseases of the Commission on State Departments met December 2 in Madison to discuss three items of current significance in that field.

Among the matters discussed were:

1. The M'Naughten Rule in Wisconsin.
2. Communications between psychiatrists and county judges both locally and statewide.
3. Testimony of psychologists on commitment proceedings.

Members of the subcommittee are Doctors A. A. **Lorenz**, Eau Claire, chairman; Keith **Keane**, Appleton; Charles **Wunsch**, Green Bay; T. J. **Nereim**, Madison; E. M. **Burns**, Madison; Charles **Belcher**, Winnebago; J. T. **Petersik**, Oshkosh; Charles W. **Landis**, Milwaukee; and Walter J. **Urben**, Madison.

Rural Health Meeting Set

The Council on Rural Health of the American Medical Association has announced that the Third Regional Rural Health Conference will be held May 18–19 in Des Moines, Iowa.

The conference, which will include 13 midwestern states, will cover the following topics:

1. What We Should Know About Health Insurance
2. Gimmicks and Gadgets of Medical Quacks
3. Animal Diseases and Human Health
4. Disaster Medical Care—Medical Self-Help Training Program
5. Effective Community Cooperation in a Medical Scholarship and Loan Fund Program

Dr. D. E. **Dorchester**, Sturgeon Bay, chairman of the Commission on Public Relations and Communications will represent the State Medical Society of Wisconsin at the conference.

Dane County Medical Society Has Demonstration For Firemen

The Dane County Medical Society, in one of the first programs of its kind in the state, trained some 175 Madison firemen in closed chest cardiac massage during January.

Instructor for the four programs for the city firemen was Dr. Karl **Siebecker**, professor of anesthesiology at the University of Wisconsin Medical School.

With the aid of a manikin and special film, supplied by Smith, Kline & French Laboratories, Philadelphia, Pennsylvania, Doctor Siebecker explained and demonstrated the newly developed technique designed to reduce deaths from drowning, electrical shock and other medical emergencies.

The training was mainly aimed at the rescue squad of the Madison Fire Department; but since the nearest engine company is also dispatched to the scene of an emergency, it was given to all personnel of the department.

Representatives of a number of statewide organizations also attended the session and plans are now being developed to present the training to special personnel in various sections of the state, under sponsorship of the Charitable, Educational and Scientific Foundation of the State Medical Society.

Lower Rates In SMS Life Insurance Plan

Three important developments in the State Medical Society of Wisconsin Life Insurance Plan have been announced by Bankers Life Company, Des Moines, Iowa, the underwriters of the program for member physicians.

1. Enrollment has been reopened for a three-month period beginning February 1, 1962.
2. Premium rates have been lowered.
3. Members under 60 years of age and not now insured for the full amount may apply for an additional $10,000 unit at the new rate. Members age 60 through 64 may apply for an additional $7,500 unit. The additional unit is subject to evidence of insurability.

Folders explaining these new developments have been mailed to all State Medical Society members.

In the life insurance plan, designed exclusively for members of the Society, physicians under 60 years of age can carry up to $20,000 insurance and those 60 through 64 can carry a total of $15,000.

The life insurance plan was first offered in November, 1957. Now, after four years experience, enrollment has been reopened with a substantial reduction in rates.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

Is your disability income insurance up-to-date?

To find out, apply these tests:

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President Lokvam Praises Nationwide Plan Of Blue Shield Coverage For Those Over 65

Announcement on January 18 by the AMA and National Association of Blue Shield Plans of a uniform, nationwide Blue Shield program of surgical and medical care benefits for persons over the age of 65 brought a strong statement of support from Dr. Leif H. Lokvam, Kenosha, president of the State Medical Society of Wisconsin.

"This shows that the imposition of added payroll taxes as currently proposed by the Kennedy administration is unnecessary to provide adequate and reasonably priced coverage to those 65 and over," he stated.

LEIF H. LOKVAM, M.D.
President
State Medical Society

The nationwide program will be available at an estimated cost of about $3.00 per month, according to the Blue Shield announcement. Blue Shield plans are urged to put it in operation as soon as possible.

"With this development, and when Wisconsin implements the Kerr-Mills Act, the people of this state 65 and over can have insurance coverage second to none," Doctor Lokvam continued. "Fortunately the Wisconsin Kerr-Mills proposal gives a person the choice of using state administered funds to purchase voluntary health insurance or receive direct health care benefits."

The proposed nationwide Blue Shield program would provide for surgery whether performed in a hospital or a physician's office and for medical care whether in a hospital or a licensed nursing home.

It would also provide payments for anesthesia, radiation treatments, x-ray examinations and for laboratory tests and pathology services. The extent of coverage for physicians' visits in a hospital or nursing home had not been set, but a spokesman for the Blue Shield plans indicated the program would provide no less than 30 and possibly as high as 70 visits.

It will include full payment provisions for a single person over 65 whose annual income is $2,500 or less and for a husband and wife whose combined annual income is $4,000 or under. Persons whose incomes exceed these limits could be subject to additional charges at the discretion of the individual physician.

Limitations and exclusions would be minimal, and it is contemplated that even preexisting conditions would be covered.

"The State Medical Society has long been recorded in favor of voluntary insurance. This is another big step in the right direction," Doctor Lokvam concluded.

Century Plan Rates High In Health Insurance For Aged

Announcement of a nationwide Blue Shield plan for surgical and medical care benefits for persons over age 65 has called attention to the fact that Wisconsin's aged residents have had an excellent plan available to them for nearly four years.

The "Century Plan" offered by Wisconsin Physicians Service, a division of the State Medical Society, was first offered in 1958 and was a pioneering effort in the field of health care coverage for persons over 65.

It continues to be one of the most comprehensive plans of its kind in the country, and has served as a pattern for plans in other states.

The "Century Plan" offers benefits for surgical services, anesthesia and diagnostic x-ray services associated with surgery, in-hospital medical services, radiation therapy and pathology services, hospital and nursing home benefits and some institutional care for nervous and mental illness, all with a minimum of exclusions.

Benefits for physicians services under this plan are subject to the "full payment" provisions if the person covered is below the $2,000 annual income level, or husband and wife are below the $3,600 income level.

Some other valuable provisions of the plan are:

1. No physical examination is required.
2. Coverage of preexisting conditions after a waiting period of 9 months.
3. No health condition riders which would restrict the provisions of the contract.

The plan is offered at $9.00 per person per month, which compares favorably with figures quoted for nationwide plans. The proposed Blue Shield cost is reported at $3.00 per month, as previously stated, and a similar nationwide companion contract for hospital services for those 65 and over would cost an estimated $10 to $12.

Currently, nearly 8,000 persons are covered by the WPS "Century Plan" contract.

Capitol Comment

NESTIGEN POSSIBLE HEW SECRETARY

Ivan Nestigen, former mayor of Madison, may move up to Secretary of Health, Education and Welfare if Abraham **Ribicoff**, present secretary, runs for the U. S. Senate, according to recent press reports.

Nestigen has been under-secretary in the department since January, 1961. He has been active in promoting the Kennedy administration proposal to provide medical care for the aged through social security.

KING–ANDERSON FEARS "GROUNDLESS"

Rep. Robert Kastenmeier (D-Watertown), speaking at the Dane County Medical Society's annual Press Dinner, told the physicians their fears that a social security program to finance health care costs would mushroom into a full-blown socialized medicine were "groundless". Kastenmeier said the public "would not stand for endless increases in social security taxes . . . that contributions of about 9 per cent total was a natural limit" in his opinion.

Physicians Recommend Use Of Nursing Home To Cut Welfare Cost

Increased use of nursing home facilities for patients who do not require intensive hospital care was recommended by the Fond du Lac County Medical Society as one means of reducing public assistance costs in their county.

As a result, a committee of physicians will be named to investigate the use of nursing home beds for those patients on the welfare department rolls who no longer require intensive care in the hospital.

County Welfare Director Joseph W. Juknialis pointed out that the county cannot make the selection as to which cases could be transferred to nursing homes. "This is up to the physicians in charge of the patients, not up to us," he concluded.

A report by the special committee will be sent to Juknialis and the Welfare board upon completion of the study.

Propose Conference On Medical Aspects Of Care For The Aging

The Division on Aging of the Commission on State Departments, meeting in Madison January 25, decided to explore the possibility of holding regional meetings on "Medical Aspects of Caring for the Aging Patient."

Dr. A. M. Hutter, Fond du Lac, chairman of the Division, was authorized to form a committee to draft plans for a series of regional meetings on the subject.

In another action, the chairman is to appoint a subcommittee to work with the Wisconsin Council of Homes and Hospitals Serving the Aged, Inc., to assist it in developing an accreditation program.

Dr. George G. Stebbins, Madison, and Doctor Hutter reported on a Joint Council on Aging Conference held in Chicago in December. The Joint Council is made up of representatives from the American Medical Association, American Hospital Association, American Dental Association and American Nursing Association.

Mr. Paul Fleer, representing the State Board of Health, reported on the progress of the Board's Rehabilitation project. He stated that the project now has four physical therapists, one occupational therapist, and a speech and hearing therapist and will be adding a social worker and second occupational therapist.

Fleer pointed out that the idea of the project is not to give therapy in the locality, but rather to instruct others who will be directly concerned in the rehabilitation of patients. He stated that the service has now been presented in most counties in the state.

Dr. George G. Stebbins, Madison, left, and Dr. A. M. Hutter, Fond du Lac, right, review the program of the Joint Council on Aging Conference held in Chicago in December. Both physicians attended the conference.

The Division also decided to have a standing panel of speakers on the medical aspects of aging available for scientific portions of the meetings of county medical societies.

Dane County Society Presents Press Award

The Dane County Medical Society, on February 9, presented an award for outstanding reporting on a medical subject to Elliott Maraniss, staff reporter of *The Capital Times*, Madison.

The award was given for his reporting of the year-long controversy at the University of Wisconsin Medical School. Presentation was made at the Seventh Annual Press Dinner held that evening.

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Governor Outlines Projects Of New State Commission On Aging

R. W. Bardwell, Madison, was named chairman of the new State Commission on Aging and Dr. Patricia Lanier, Kewaunee, vice-chairman, at the commission's organizational meeting in Madison January 30.

Bardwell is retired director of the Madison Vocational School. Doctor Lanier is a practicing physician in Kewaunee and a member of the Division on Aging of the Commission on State Departments of the State Medical Society. Other members are: Curtis Gallenbeck, Pewaukee; Stanley S. Gregory and Max Taglin, both of Milwaukee; Albert Blumenthal, Eau Claire; and Milo K. Swanton, Madison.

The commission was created by the 1961 Legislature at Gov. Gaylor Nelson's request, to give information, assistance in planning, and advice to private and governmental groups concerned with the aging and retired persons and to recommend legislation.

The Governor suggested that the committee investigate the following:

1. State retirement laws to see if it would be feasible to allow retired employees to work part time in government service.

2. Compulsory retirement laws at a fixed age in government and industry and consider a "deceleration by stages" program to fit people for retirement.

3. Use of vocational rehabilitation schools to retrain older workers who have the desire and capacity to continue work.

4. Expansion of shelter workshops for older workers unable to compete in the usual work environment.

5. Correction of the widespread impression of many employers that chronological age alone is a reliable measure of job ability.

6. Expansion of recreational activities for the elderly.

7. Investigation of the housing situation and encouragement of housing for the elderly.

8. Study of the best method of providing medical care for the aged either through social security or some other method.

Dr. Patricia Lanier, Kewaunee, seated, explains the functions of the State Commission on Aging, of which she is a member, to, left to right, Dr. G. M. Shinners, Green Bay, Dr. S. F. Sivertson, La Crosse, and Dr. Craig Larson, Milwaukee. The four physicians are all members of the State Medical Society's Division on Aging.

State Society Gives Warning On Hypnotism

The State Medical Society, in a news release to communications media of the state and notification to school administrators, has warned against use of hypnosis for entertainment purposes in schools.

"Hypnosis is not a game," warned Dr. Keith Keane, Appleton, chairman of the Division on Nervous and Mental Diseases of the Commission on State Departments. "It is a serious scientific aid for diagnosis and treatment and should be used accordingly."

Doctor Keane's warning came after the Society received reports that a performer has scheduled programs in several Wisconsin high schools to demonstrate the effects of hypnotism with student volunteers.

The Division has been concerned about the abuse of hypnosis and recommends that it be used only when there are sound medical reasons, and then only by properly trained personnel.

Governor Gives Views On Aged Health Care

Gov. Gaylord Nelson, in a talk before the newly established State Commission on Aging, said he favors extension of the Social Security system to include medical aid for elderly citizens.

"Such an extension would reflect the principle of contribution, during the working years, of funds identified to provide such health service as possible in old age . . . It is independent of the financial capacities of the individual states and avoids the application of the means test," he said.

The Governor said he was aware there would be disagreement on the commission with his positon and added:

"If this occurs, you should in turn, I feel, investigate alternative programs which could be expected to meet our responsibilities in this area.

"The problem of helping older citizens secure adequate medical attention and treatment is a national problem. It calls for national responsibility and national action."

News Briefs

RACINE COUNTY SECRETARY

Gilbert J. Geraghty, Racine, has been named executive secretary of the Racine County Medical Society. The new executive secretary is an attorney.

SPORTS MEDICINE NEWSLETTER

"Medicine In Sports," a newsletter devoted exclusively to reporting the latest information on the care and prevention of athletic injuries, is now being distributed to all physicians interested in the subject by the Rystan Company, Mount Vernon, New York.

Physicians interested in receiving the publication are invited to send their requests to: Charles Stanton, Editor, "Medicine In Sports," % The Rystan Company, 7 North MacQuesten Parkway, Mount Vernon, New York.

Proposed Chiro "Research" Rules Hit Snag

Proposed rules to give the State Board of Examiners in Chiropractic regulatory power over "chiropractic research" ran into opposition at a public hearing January 23 in Milwaukee.

Speaking against the proposed rules were Robert B. L. Murphy, Madison, legal counsel for the State Medical Society; O. L. Hidde, Watertown chiropractor, president of the Society of Wisconsin Chiropractors, Inc.; and Stewart Honeck, Milwaukee, legal counsel for the same group.

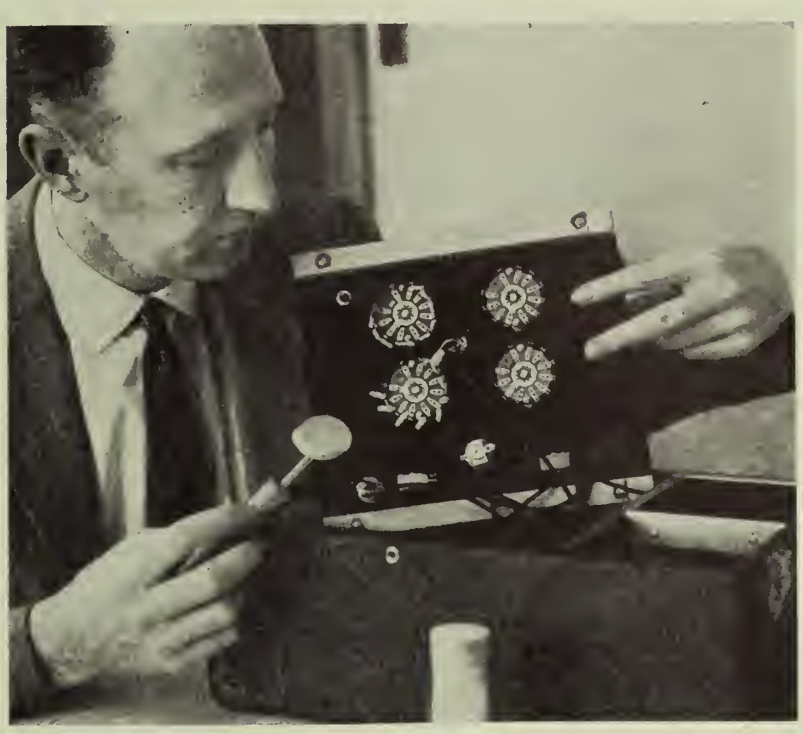
Acting under direction of the Council of the State Medical Society, Murphy voiced two general arguments:

1. There is no authority in Wisconsin Statutes for the chiropractic board to propose, adopt or enforce such rules and that if such authority did exist, the proposed rules would need substantial revision for the protection of those people who would permit themselves to be the objects of "chiropractic research".
2. There is an important question of public policy and scientific desirability—which would be extended to medicine, dentistry, law, architecture, engineering and education—in having any purely licensing body seek to control the research efforts of autonomous corporations.

Murphy had some questions for the board: What is meant by "chiropractic research"? What individuals may conduct such research? What kind of information is supposed to be gathered by such research?

"As a practical matter," he asked, "just how carefully can it be expected that a patient on whom research is to be done will read the notice which the proposed rules would require to be posted in the chiropractic office or on any instrument used in the course of such 'research'? Again, as a practical matter, what difference will it make if he does read the notices?"

"In the case of an aggressive individual or organization, might not notices of alleged 'research' readily become a device for puffing the regular practice of such chiropractor or chiropractors . . . ?"



THE "BLACK BOX" which was declared a fraud in 1958 is still the center of controversy among chiropractors. Above Dr. Robert Zach, Monroe, chairman of the Commission on Public Policy, shows the internal structure of the device, pointing to two dials which were not even wired up. Its successor, called a "research model", is purported to be the central issue in some proposed rules for chiropractic "research" presently before the State Board of Examiners in Chiropractic.

"If an instrument has no known diagnostic, analytical or therapeutic value, is it scientifically valid or desirable as a matter of public safety to use such an instrument on a member of the public merely because he consents to such use?", Murphy asked.

"In light of the history of some of these devices in this state, it is believed that the key to the problem of control here may be the regulation of the devices rather than regulation of 'research' or of 'investigators' who may not know what they are doing or its consequences," he concluded.

Testimony by the chiropractors, for the most part, was a continuation of a feud between two factions which first erupted in a legislative hearing in November.

Honeck stated, "The proposed rules appear to be custom tailored to lend validity to the use of instruments such as the discredited 'black box' and the so-called 'research model' which have been condemned as fraudulent devices before our state legislature."

House Cleaning

Following the January 23 hearing on proposed rules for chiropractic "research", which involved testimony on the infamous "black box" and its successor called a "research model", the Society of Wisconsin Chiropractors "Newsletter" had this to say:

"Legislators and legal advisors have told us that it would be much better if the chiropractic profession cleans its own house, rather than to have the medical profession do it for us. It certainly is clear from the hearing of January 23 that the Medical Society is prepared to do such house cleaning if we do not pursue these efforts."

County Society Presidents, Secretaries Will Hold Annual Meeting At AMA Headquarters

Representative Durward Hall of Missouri will be the featured speaker at the Third Annual Conference of Presidents and Secretaries of County Medical Societies in Wisconsin.

The conference, to be held Friday, March 16, will be at the American Medical Association headquarters in Chicago.

Representative Hall is a physician and will give his impressions of the current legislative situation in Washington as it affects medicine.

This is the first time the conference is being held outside the state; purpose is to give the presidents and secretaries information on the many functions performed by the American Medical Association.

The program, which will start about 9:00 a.m., will include meetings with AMA officials, outline of the programs and activities of the organization, and tours of the building. Congressman Hall will speak at the noon luncheon, and the program is expected to conclude about 3:45 p.m.

Plan Special Events At 1962 Annual Meeting

Two special programs for the Annual Meeting, set for Milwaukee, May 8–10, have been announced by the Commission on Scientific Medicine. They are a special demonstration of the Closed Chest Cardiac Massage technique and a conference on Medical Aspects in Sports.

The cardiac message program, to be held Wednesday morning, May 9, will include films on the relatively new procedure combined with mouth-to-mouth resuscitation and a demonstration of the techniques. Making the presentation will be Dr. Karl Siebecker, Madison.

A second portion of the program will feature Dr. John H. Huston, Milwaukee, talking on "The External Afibrillator".

During Wednesday afternoon and Thursday morning, Doctors Siebecker and Huston will give individual demonstrations at the auditorium.

On Wednesday afternoon, the Special Medical Conference on Medical Aspects In Sports will begin with a discussion of "Physical Examinations for High School Sports Participants" by Fred V. Hein, Ph.D., of the American Medical Association, and Dr. William H. Bartlett, Madison. The second part of the program will be a presentation of "Conditioning and Withholding From Participation" by Dr. Robert Murphy, Columbus, Ohio. This will be followed by a panel discussion by Doctor Bartlett, Dr. George E. Collentine, Milwaukee, and a third physician. Moderator of the entire program will be Dr. J. C. H. Russell, Fort Atkinson.

Every physician connected with high school athletic programs is urged to attend and participate in the discussion.

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News Briefs

WAPH MEETING SCHEDULED

"Public Health of the People, for the People, and by the People" has been selected as the theme of the annual meeting of the Wisconsin Association of Public Health, scheduled for June 19–20 in Madison.

Dr. Josef Preizler, Madison, is program chairman.

DCMS RESEARCH FUNDS AVAILABLE

Individual grants not to exceed $2,000 are available for support to medical research, according to the directors of the Dane County Medical Society Foundation for Medical Research.

The funds come through the James and Clara Joss Foundation.

Deadline for applications is March 1. Further information may be obtained from Dr. William B. Parsons, Jr., 30 South Henry Street, Madison.

"Something Important For Every MD" At 1962 Annual Meeting In May

Working closely with the various specialty societies and the Wisconsin Academy of General Practice, the Commission on Scientific Medicine has prepared an outstanding program for the Annual Meeting in Milwaukee, May 8–9–10. To give you an opportunity of planning your attendance, the outline of the Scientific Program is included in the January and February issues of the JOURNAL. The March issue will include full details, and *around the latter part of March a special announcement on the noon scientific luncheons will be sent you.*

PLAN NOW TO ATTEND, AND MARK YOUR CALENDAR FOR THESE DATES

TUESDAY, MAY 8

★ **9:30–12:00 a.m.**

Your Female Patient and Special Problems She Presents

★ **9:30–11:45 a.m.**

Special program on Cardiology

(Arranged in cooperation with the Wisconsin Society of Internal Medicine)

★ **12:00 noon**

Round Table Luncheons and Special Alumni Luncheons

1. **THE EMERGENCY TREATMENT OF THE COMPLICATIONS OF CORONARY OCCLUSION,** by **Arthur M. Master, M.D.,** New York City
2. **ENDOMETRIOSIS,** by **Ralph A. Reis, M.D.,** Chicago
3. **HORMONAL CYTOLOGY,** by **George L. Wied, M.D.,** Chicago
4. **PROBABLE EFFECT OF COMMUNITY AGENCIES ON THE PERSONALITY DEVELOPMENT OF CITIZENS,** by **Maurice E. Linden, M.D.,** Philadelphia

★ **2:00 p.m.**

Special Teaching Programs

1. **Internal Medicine**
2. **Obstetrics and Gynecology**
3. **Pathology**
4. **Psychiatry**

★ **6:00 p.m.**

Buffet dinner for delegates and officers

★ **7:15 p.m.**

Second session, House of Delegates

WEDNESDAY, MAY 9

★ **9:00 a.m.**

Third session, House of Delegates

★ **9:30 a.m.**

CLOSED CHEST RESUSCITATION

(Program arranged in cooperation with the Wisconsin Academy of General Practice. Participation in this program and afternoon programs will provide 6 hours of Category I credit for AAGP members.)

1. **MOUTH TO MOUTH RESUSCITATION** (movies with comments) and **CLOSED CHEST RESUSCITATION,** by **Karl Siebecker, M.D.,** Madison
2. **DEMONSTRATION OF TECHNIQUE** (individual instruction in afternoon), by **Karl Siebecker, M.D**
3. **THE EXTERNAL AFIBRILLATOR,** by **John H. Huston,, M.D.,** Milwaukee

IMPORTANCE OF ATTENDANCE! Because local groups of firemen, lifeguards, law enforcement officers, etc. will request M.D. instruction in this technique, it is important that *every hospital staff in the state* has at least one M.D. in attendance at the morning program and at one of the instructional periods.

★ 11:30 a.m.

CLINICAL TRIALS WITH LIVING ATTENUATED MEASLES vs. VIRUS VACCINE, by **Fred R. McCrumb, Jr., M.D.,** Baltimore

(Lecture sponsored by Wisconsin State Board of Health)

★ 12:00 noon

Round Table Luncheons

1. **PHYSIOLOGICAL EVENTS PRECEDING STEROID-INDUCED DIURESIS IN NEPHROSIS,** by **William J. Oliver, M.D.,** Ann Arbor, Mich.
2. **PRESENT STATUS OF ANTIBIOTIC THERAPY,** by **Burton A. Waisbren, M.D.,** Milwaukee
3. **ROLE OF EMBOLI IN PRODUCING LIMB ISCHEMIA,** by **A. W. Humphries, M.D.,** Cleveland, Ohio
4. **REHABILITATION IN ARTHRITIS** (panel)
5. **NEWER DRUGS AND THEIR USES,** by **Ovid Meyer, M.D.,** Madison
6. **DYSMENORRHEA,** by **Edmund R. Novak, M.D.,** Baltimore, Md.
7. **MEASLES AND MEASLES PROPHYLAXIS** (including measles encephalitis), by **Fred R McCrumb, Jr., M.D.,** Baltimore, Md.
8. **SPECIAL LUNCHEON**
   Charitable, Educational and Scientific Foundation (Reports and election of officers. Each county chairman expected to be in attendance. No charge for luncheon.)

★ 2:00 p.m.

Special Teaching Programs

1. **Pediatrics**
2. **Orthopedic Surgery**
3. Special M.D. Conference on **MEDICAL ASPECTS OF SPORTS**
   (Conference sponsored by the Division on School Health of the Commission on State Departments, in cooperation with the Wisconsin Interscholastic Athletic Association.)

   CLOSED CHEST RESUSCITATION, demonstration and explanation with manikin, by **Karl Siebecker, M.D.**

★ 6:30 p.m.

President's Reception (for those attending annual dinner)

★ 7:15 p.m.

Annual Dinner

THURSDAY, MAY 10

★ 9:00 a.m.

Closed Chest Resuscitation Demonstrations, by **Karl Siebecker, M.D.,** Madison

★ 9:30 a.m.

Wet Clinic on Dermatology and Allergy

(Cases presented through **Donald M. Ruch, M.D.,** Milwaukee, for the Wisconsin Society of Dermatology, and **Harry R. Weil, M.D.,** Milwaukee, for the Wisconsin Society of Allergists.)

★ 12:00 noon

Round Table Luncheons

1. **CHOLANGITIS,** by **C. B. McVay, M.D.,** Yankton, S.D.
2. **NEWER ROENTGEN METHODS IN EXAMINATION OF THE KIDNEY,** by **John A. Evans,** New York City
3. **SOME CONSIDERATIONS OF METHODS FOR INCREASING THE EFFECTIVENESS OF TOPICAL CORTICOSTEROID PREPARATIONS,** by **Leon Goldman, M.D.,** Cincinnati, O.
4. **PATCH TESTING: INDICATIONS AND TECHNICS,** by **Adolph Rostenberg, Jr., M.D.,** Chicago, Ill.
5. **THE ANESTHESIOLOGIST AS RESPIRATORY CONSULTANT,** by **John Severinghaus, M.D.,** San Francisco, Calif.
6. **THE THEOPHYLLINE DRUGS,** by **Harry Beckman, M.D.,** and **Harold G. Hardman, M.D.,** Milwaukee
7. **INFERTILITY: ETIOLOGICAL FACTORS AND MANAGEMENT,** by **Richard F. Mattingly, M.D.,** Milwaukee
8. **SPECIAL LUNCHEON**
   Past Presidents

★ 12:00 noon

Luncheon and Scientific Program of the Section on Ophthalmology & Otolaryngology

CANCER OF THE LARYNX, by **Walter P. Work, M.D.,** Ann Arbor, Mich

TEMPORAL ARTERITIS, by **Robert W. Hollenhorst, M.D.,** Rochester, Minn.

★ 2:00 p.m.

Special Teaching Programs

1. **Anesthesiology**
2. **Radiology**
3. **Surgery**

(Official meeting of Wisconsin Surgical Society, but lecture portion of program open to any physician registered for the annual meeting. Business meeting for members of the Wisconsin Surgical Society only.)

One of the best scientific exhibit displays has been arranged for this year. You'll want to participate in some of them. Test your own skills and knowledge.

OUT-OF-STATE GUEST LECTURERS
1962 Annual Meeting

DONALD E. CASSEL, M.D., Chicago
Professor of Pediatrics, University of Chicago Medical School

VINCENT J. COLLINS, M.D., Chicago
Director, Department of Anesthesia, Cook County Hospital

JOHN A. EVANS, M.D., New York City
Professor of Radiology, Cornell University Medical College

LEON GOLDMAN, M.D., Cincinnati
Professor of Dermatology, University of Cincinnati Medical School

ALAN GUTTMACHER, M.D., New York City
Chief of Obstetrics and Gynecology, Mt. Sinai Hospital; Clinical Professor of Obstetrics & Gynecology, Columbia University College of Physicians & Surgeons

R. W. HOLLENHORST, M.D., Rochester, Minnesota
Associate Professor of Ophthalmology, Mayo Foundation Graduate School (Univ. of Minnesota)

ALFRED W. HUMPHRIES, M.D., Cleveland
Associate Professor of Vascular Surgery, Frank E. Bunts Institute (Clev.)

ORMAND C. JULIAN, M.D., Chicago
Professor of Surgery, University of Illinois College of Medicine

MAURICE E. LINDEN, M.D., Philadelphia
Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine

ARTHUR M. MASTER, M.D., New York City
Consultant Cardiologist, The Mt. Sinai Hospital, New York, N. Y.

FRED R. McCRUMB, JR., M.D., Baltimore
Director, Division of Infectious Diseases, University of Maryland School of Medicine

CHESTER B. McVAY, M.D., Ph.D., Yankton, S.D.
Clinical Professor of Surgery, University of South Dakota Medical School; Associate Professor of Anatomy, University of South Dakota Medical School

ROBERT A. MILLER, M.D., Chicago
Assistant Professor of Pediatrics, Northwestern University School of Medicine

ROBERT MURPHY, M.D., Columbus, Ohio
Ohio State University

EDMUND R. NOVAK, M.D., Baltimore
Assistant Professor of Obstetrics & Gynecology, Johns Hopkins University School of Medicine

WILLIAM J. OLIVER, M.D., Ann Arbor
Assistant Professor of Pediatrics, University of Michigan Medical School

DAVID G. PUGH, M.D., Rochester, Minnesota
Associate Professor of Radiology, Mayo Foundation Graduate School (University of Minnesota)

RALPH A. REIS, M.D., Chicago
Professor of Obstetrics & Gynecology, Northwestern University School of Medicine

ADOLPH ROSTENBERG, JR., M.D., Chicago
Professor of Dermatology and Chairman of the Department of Dermatology, University of Illinois College of Medicine

ROBERT E. SCULLY, M.D., Boston
Assistant Clinical Professor of Pathology, Harvard University School of Medicine

JOHN W. SEVERINGHAUS, M.D., San Francisco
Associate Professor of Anesthesiology, University of California Medical School

GEORGE L. WIED, M.D., Chicago
Associate Professor of Obstetrics & Gynecology, University of Chicago, and Director of Cytology, University of Chicago Hospitals

WALTER P. WORK, M.D., Ann Arbor, Michigan
Professor of Otolaryngology, University of Michigan Medical School

JOSEPH M. JANES, M.D., Rochester, Minnesota
Professor of Orthopedic Surgery, Mayo Foundation Postgraduate School, University of Minnesota

1962 SPRING TOURNAMENT OF THE WISCONSIN STATE MEDICAL GOLF ASSOCIATION AT TUCKAWAY COUNTRY CLUB, MILWAUKEE, MONDAY, MAY 7

Reservations for golf and dinner at $14 per person can be made directly to the Wisconsin State Medical Golf Association, A. H. Luthmers, Executive Secretary, 756 N. Milwaukee St., Milwaukee 2, Wis.

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: THE WOMAN'S AUXILIARY TO THE STATE MEDICAL SOCIETY OF WISCONSIN

MILWAUKEE AUDITORIUM . . . MAY 8–10, 1962

Watercolors and Oils Only

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or *his wife* may submit an entry.

LIMITED ENTRIES: Up to 3 pictures per person may be submitted for exhibit.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Doctor and Mrs. William F. Hovis, Jr., Milwaukee, *on or before April 1, 1962. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)*

REQUIREMENTS: (1) All pictures must be framed, with wire and screw eyes attached.

(2) All pictures must be delivered to the Dressing Room on the east side of the Stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 7, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 10.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the two categories will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon. Judge: Edward Dwight, Director of the Milwaukee Art Center.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

Notification of Intent to Exhibit

Mail to Doctor and Mrs. Wm. F. Hovis, Jr.—304 E. Bradley Road, Milwaukee 17, Wisconsin, BEFORE APRIL 1, 1962.

I plan to submit a painting, or paintings, for the 1962 MEDICAL ART SALON at the Milwaukee Auditorium, May 7–10.

My entry, or entries, will be:

(1) Watercolor_____ Oil _____ Size _____" wide and _____" deep
(2) Watercolor_____ Oil_____ Size _____" wide and _____" deep
(3) Watercolor_____ Oil_____ Size _____" wide and _____" deep
(1) Title: _____ (2) Title: _____
(3) Title _____

Name: _____

Street: _____

City: _____

the Wisconsin Medical Journal

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Dilemmas of Clinical Surgery

A Presidential Address

By JACK A. KILLINS, M.D.

Green Bay, Wisconsin

THE MARCH, 1962, issue of THE WISCONSIN MEDICAL JOURNAL *contains the papers presented at the May, 1961, meeting of the Wisconsin Surgical Society. The papers have preempted the scientific section of* THE JOURNAL.

Heretofore some of the papers have been published indiscriminately in various medical journals throughout the country, and some have never been preserved with printer's ink. This is probably a good thing. Not all that is said at medical meetings needs or deserves to be printed.

Nevertheless, the recorder of our society is required to obtain a copy of the literary efforts of our speakers and preserve them forever with our records. These records soon will be stored in the new Middleton Medical Library at Madison. They will be readily available to students and physicians, and it is hoped they will be of value for study, research, and reference.

The Wisconsin Surgical Society expresses its thanks to the editors of THE WISCONSIN MEDICAL JOURNAL *for publishing the papers of our friends, colleagues, and teachers.*—J. W. MCROBERTS, M. D., Recorder, Wisconsin Surgical Society.

I HAVE BEEN looking forward to the prospect of exhibiting some menopausal symptoms in public, so the prospect of a presidential address is especially intriguing. First, however, it gives me an opportunity to thank you for the honor of being chosen as your president during the coming year; and I do thank you most sincerely. This is one of the few events in my professional life of sufficient importance to warrant inclusion in my obituary—not that there is any rush about that—but it is a distinct honor and I am truly grateful.

This society must represent one of the most highly educated groups in the state—if there is any question about our erudition, I'm sure no one would deny that collectively we must represent very nearly the ultimate in vocational training.

A presidential address may take several forms. One is the scientific paper. I have

Presidential address presented before the Wisconsin Surgical Society at the 120th annual meeting of the State Medical Society of Wisconsin, May 4, 1961, Milwaukee.

tried that on a few occasions before this group with equivocal results. I well remember my first such paper dealing with a case report and my observations on total gastrectomy. The program committee was especially gratified because there was such good audience response. When I concluded, there was a sea of hands waved by men who wanted the floor to tell why their way was better. Since this was my first case, practically everyone could claim greater clinical experience. I had spoken of the difficulties with the longitudinal muscle fibers of the esophagus and the difficulty in suturing it—I can still hear Forester Raine saying, "As far as I'm concerned, there is nothing in the wall of the esophagus but the mucous membrane." I have not chosen another case report for today's presentation.

Another form of presidential address is the one that looks back with pride and forward with hope. I am well aware that Wisconsin has a surgical heritage of which any state could be proud and that it is being advanced effectively by the men throughout the state, especially those in our two university teaching centers—but I have no qualifications to speak on this theme.

A variation of this approach is the address entitled, "Mistakes I Have Made in Fifty Years of Surgery." Since most of my mistakes have some time to run on the statute of limitations, I have no intention of discussing them publicly, even before such a charitable audience as this.

I do hope that we can explore with mutual benefit some of the common problems of clinical surgical practice. I call them dilemmas and that is an appropriate expression—there isn't an all right nor all wrong answer to these situations, but perhaps by discussing them a little while today it will help to develop that intelligent and honest apercus that makes it possible to see ourselves as others see us.

Among the dilemmas I have chosen are:

CLINICAL JUDGMENT vs SCIENTIFIC MEDICINE

We practice the intangible combination of experience and hunch called clinical judgment every day. Surely the young woman who comes in with a large movable lump in the breast, her breasts already scarred from previous excisions until she looks like a fugitive from a primitive fertility rite, can have this present cyst aspirated and sent on her way without being admitted to the hospital, intubated, anesthetized, painted from the neck to navel and the area excised while the family paces the hall waiting for the diagnosis to be relayed to them through the surgical hierarchy.

Must every patient who has a thrombosed hemorrhoid, even in the interests of good medicine, be subjected to a proctoscopic examination, a colon x-ray and a recheck visit in three months?

The woman in her late forties who misses one period and comes to the physician because she is afraid she is pregnant—who has a normal pelvis on examination and a negative "Pap" smear—can wait a month or two before she has a "D & C," an analysis of her steroids and that ubiquitous diagnostic procedure, the "Pelvic Lap."

These are but examples, however, and here is the other horn of the dilemma—clinical judgment as a willful and capricious mistress—the patient who is reassuringly patted on the shoulder and told, "We can always check into it further if it persists," may be missing the one chance he has for early diagnosis and definitive treatment. You'll never know if you don't look!

EMOTIONAL SELF DELUSION vs OBJECTIVE EVALUATION

The classic example of emotional self delusion is the hemostat that tears from the patient lying unconscious before us and the surgeon looks at the clamp in his hand in pained surprise and says, "This _____ tissue is sure friable."

A more subtle form of self delusion occurs in patients who are "nervous," or "unreasonable," or "demanding" when in reality they are sick and not doing as well as we had hoped or as we had consciously or unconsciously led them to believe. Our punctured pride and defensive attitude are often responsible for, or at least aggravates, the patient's nervous or unreasonable behavior.

I never could understand why the physician who sees 50 to 60 patients a day is presumed to know them so much more intimately than the man who sees 10 or 12. Kidding patients is in good taste only rarely,

but at least we should avoid the sin of kidding ourselves.

The common belief that doctors and doctors' wives make poor patients and are the recipients of more than their share of surgical catastrophies and complications is, I am sure, because we identify ourselves emotionally with their difficulties. We bend over backwards to smooth their path and help them to avoid the rules of good practice only to become ensnared by our own concessions. Such difficulties as they do have are long remembered because, in a sense, each complication happens to us and is therefore less easily dismissed from our consciousness.

MONOTONY vs PROBLEM CASES

The Mr. Mitty in all of us dreams of sitting as sort of an oracle being called only in difficult and unusual cases which we solve with a piece of broken fountain pen, as Mr. Mitty did, or by the natural exercise of our superior capabilities. Unfortunately, a round object in the road is more likely to be a rock than a dinosaur egg, and we may well accept the fact that longing for unusual and dramatic situations is a neurotic symptom in us and just as unlikely to be fulfilled as in Mr. Mitty's day dreams.

A sincerely interested surgeon finds more unusual cases than the plodder. There are no routine examinations—only routine examiners. I recall a friend who, in the war years, was re-examining a group of men previously examined and rejected for cardiovascular difficulties. In a single afternoon he discovered three previously undiagnosed coarctations of the aorta. When I complimented him, he passed it off by saying, "I just routinely feel for the femoral pulse in every case of hypertension."

I think it is permissible to deliberately change the pace and vary the routine to avoid boredom. There is a story, probably apocryphal, about old Doctor Buchanan who, on one occasion when doing a routine life insurance examination on a young farmer and receiving routine noes to routine questions concerning routine diseases, said, "Oh, that's too bad; they like to have you have a little something;" whereupon the farm boy eagerly inquired, "Would clap do?" Such unsophisticated farm boys are no longer extant in Brown County.

THE PATIENT'S USUAL ATTITUDE vs THE "YOU'RE THE DOCTOR" ATTITUDE

The most patronizing expression in medicine is "the family physician" or its even more contemptuous abbreviation, L.M.D. for local M.D., as it is used by members of the resident staffs in many large medical institutions. I have a friend who, like myself, is proud to have been a Fellow at the Mayo Clinic. He tells of returning to the scene of his graduate training and being asked by an unctous and slightly patronizing Fellow, "Where are you from, doctor?" George said, "I'm from Elsewhere—where the mistakes are made."

The patient's attitude is often entirely different when he first consults his home physician than it is six months later when the symptoms persist and he travels some distance expecting to stay several days for a "thorough examination." Initially, at home, he may stop in for a "little check-up," may mention his complaint casually and suggest, "Something to fix me up until after the sales meeting."

Proper professional conduct does not permit selling the patient on examinations and diagnostic tests in the same way he is sold accessories for his car, but a proper explanation is not only permissible but also essential. But a curious coincidence some people do not receive as thorough an examination as they deserve because of a misguided attempt on the part of the physician to save the patient money.

Such efforts are poor medicine; they are rarely appreciated by the patient who simply goes somewhere else for a more expensive and more thorough examination.

COMMUNITY DEMANDS vs TIME FOR INDIVIDUAL PATIENT CARE

Here is a subject on which I speak with some authority. I have eaten more tepid soup, limp sandwiches, and creamed chicken and peas at my own expense in the cause of community betterment than any physician of my acquaintance. I have been a member of the Community Chest board of directors for six years, school board member, president of a service club and so on ad infinitum. As a surgeon in group practice I actually have more free time than some men, and I must

confess that I'm enough of a ham to enjoy some of the assignments. I wish I could report that my experiences have been uniformly rewarding to both myself and to the community—unfortunately this has not always been the case. You wouldn't believe the trivia on which committees waste their members' time, unless you care to recall your last hospital staff discussion of conductive shoes or dressing trays vs dressing carts. Maybe the committees would be more efficient if there were more men of your education and background to serve on them.

My experiences have not all been frustrating. If you participate in such group committee efforts you will be impressed, as I have been, with the high caliber men from the business executive group that give their time year after year in the cause of community service. You will be talked up to with refreshing frankness by people who are happy to have your help as an equal but who don't accord you the obsequious "yes, doctor" you have become accustomed to at the hospital. Contributions you may make here may be less spectacular but just as valuable as those in the field of individual patient care. In our Society, Dr. Jerry McRoberts and his committee working on a uniform ambulance ordinance is an example of community service where in their knowledge and ability as surgeons enables them to make a unique contribution to the community.

The time spent in such efforts is the same stuff so casually frittered away in staff room bull sessions and coffee breaks. There is almost never a community job that takes as long at one time as a game of golf. Finally, if you really aren't the type for this sort of thing, you can give generously in support of worthwhile community health, welfare and recreational projects. As a group we have been remarkably well treated by the communities in which we live—an understanding of the problems and simple gratitude should motivate a generous response.

PRIDE vs OBJECTIVE EVALUATION OF THE NEED

Men of our training and background have every right to be proud of our capabilities. Our patients rarely appreciate how important that pride is in their care. I venture that it is as important as the widely disseminated propaganda concerning relief of suffering. Even this excellent motivation can be overdone. Formal consultation within our specialty can be increased with help to both the surgeon and the patient. We are all reluctant to discuss our problems while they are still an urgent daily care, but another head and a fresh viewpoint is sometimes reassuring if we are right and may be life-saving if it uncovers a psychic blind spot. Pride sometimes encourages extensive surgery that can't be justified on the basis of probable benefit to the patient. Good surgeons try not to let their pride urge them into cases that will be little better off even if, surgically speaking, the operation is successful.

In this day of easy and rapid transportation there is no need for every conceivable kind of elective surgery being available in every community. Some cases are best treated by men and teams of men qualified by training and experience to care for them. Each community need not repeat the heartbreaking mortality of the pioneers just to inflate the ego of their open heart surgeons.

THE DUMB SURGEON vs. THE SCIENTIFIC DIAGNOSTICIAN

As surgeons, we have been stimulated to worthwhile contributions just to prove our capabilities. Dr. Kenneth Sauter said of his work on blood volume studies, which he presented to this Society, that he was tired of being referred to as a dumb surgeon and thought he would do something the internists would respect.

The pendulum has swung a long way toward deprecating technical skill and ability —I am not recommending a return to Syme and the twenty-seven-second shoulder disarticulation but neither do I feel there is unlimited time for the surgical procedure while the anesthetist squeezes the bag, pours in blood replacement, and signals for a relief so that she can take her coffee break. Some postoperative complications, astutely diagnosed and scientifically treated, might better have been avoided by aggressive skillful surgery while the patient was on the operating table.

The tented common duct, the lasooed ureter, and punctured urinary bladder are still with us and avoiding them is no small accomplishment.

The obvious other horn of this dilemma is that no operation, however skillful, is helpful unless it is done on the right patient for

(continued on page 169)

New Operative Techniques in Intestinal Obstructions

A) Use of long intestinal tube
B) Inlying tube in lower colon for decompression and infusion of fluids
C) Cervical esophagostomy tube for protracted periods of gastric suction or feeding

By OWEN H. WANGENSTEEN, M.D.
Minneapolis, Minnesota

THE ENTIRE OUTLOOK in bowel obstruction has changed considerably since some of you began the practice of medicine. In the twenties, C. Jeff Miller (1929) wrote of a 60 per cent mortality in the surgical management of acute intestinal obstruction at the Charity Hospital in New Orleans. A mortality of 40 to 60 per cent was probably representative of the poor accomplishment of that day everywhere.

Hartwell and Hoguet, of New York, as long ago as 1912, described the protective action of saline solution in dogs in which high intestinal obstruction had been established experimentally. Haden and Orr (1923) postulated that this demonstrated virtue of saline solution derived from its action as an antidote to a "toxic substance x" absorbed from the obstructed gut in acute obstruction. Finding this explanation not very acceptable, I began experimenting with the problem in the fall of 1925. The mechanistic aspects of the problem appealed to me as an area for exploration. Meanwhile, experiments reported by Gamble (1925) and his associates at the Massachusetts General Hospital suggested that the effectiveness of saline solution in protecting against high-lying experimental obstructions in the dog arose from its ability to substitute for fluids and electrolytes lost by vomiting. However, even Whipple (1913) whose later work on experimental anemias and their treatment with liver won him the Nobel Prize, had expressed the opinion, on the basis of his own work, that death in intestinal obstruction was caused by the absorption of toxic proteoses—a view held by most long after Gamble's publication.

Presented before the Wisconsin Surgical Society at the 120th annual meeting of the State Medical Society of Wisconsin, May 4, 1961, Milwaukee, Wisconsin.

Doctor Wangensteen is Professor of Surgery and Chairman of the Department of Surgery, University of Minnesota Medical School.

EFFECTS OF OBSTRUCTION

The more I saw of manifestations of obstruction in the clinic and in the laboratory, the more I became convinced that the ill effects of the disorder were caused essentially by mechanical factors.[1] In the late twenties, blind enterostomy was a popular operation for acute simple obstruction of the small intestine. It astonished me to note frequently how little fluid came away through the catheter a few days following placement of an enterostomy catheter in the obstructed bowel. Similarly I noted that often only a little gas continued to escape following the enterostomy.

It was then the thought occurred to me that if restoration of functional continuity of the obstructed bowel attended drainage of small amounts of gas and fluid near the enterostomy, why not try to achieve the decompression by an inlying duodenal tube to which suction was attached? The success of the method in patients to whom it was applied was startling. In order to avoid the possibility of having been deluded, I performed operations on the early patients in the series in order to establish definitely the presence of an obstructive mechanism.

Later, as my associates and I gained confidence, we began treating selected patients with acute intestinal obstruction by suction alone. The method did not catch on immediately as most of you are aware. In fact, I found it difficult to get the suggestion published in either a clinical or an experimental journal. Like Cassandra, I was not believed. Thereupon I reverted to an old stratagem and buried the suggestion in a paper (1931) with the innocent label of "Diagnostic and Therapeutic Considerations in the Management of Acute Intestinal Obstruction"—a title to which no one could register a reasonable objection. As time passed and the method got a trial at the hands of many surgeons in various parts of the world, the method gained in popularity. In 1933, my colleague, Charles Rea, and I began some experiments in which the cervical esophagus of the dog was divided, providing a patulous proximal esophageal stoma. The distal end was closed to preclude the dog swallowing air. The terminal ileum was then obstructed. The bowel absorbed the fluid secreted into it and, when death occurred some eight weeks later, only a sausage-like lump of amorphous material just proximal to the obstruction remained in the terminal ileum (1939). This finding seemed to substantiate our belief that swallowed air was the chief source of distension in intestinal obstruction, and that suction attached to an inlying duodenal tube could be a useful agency in the prevention of, as well as in the management of intestinal distension.

DIAGNOSIS

Significance of Intestinal Colic

Intermittent pain, accompanied by grimaces of pain observed on the patient's face and by the hearing of borborygmi with the stethoscope signifies the presence of *intestinal colic*. It then only remains to decide whether the colic is owing to mechanical obstruction, enterocolitis or some dietary indiscretion.

The most difficult problem is to differentiate simple obstruction from a strangulating one. Abdominal tenderness, caused by blood in the peritoneal cavity suggests the likelihood of a strangulating obstruction. Abdominal rigidity in acute abdominal disorders varies with the severity of the irritation. Most board-like abdomens are produced by a leak of gastric contents; if the stomach has no food in it the pH may be as low as 1— a severe irritant. The exudate pus from a ruptured appendix usually has a pH of 4 to 5, and can give considerable irritation. The presence of blood, urine or feces with a nearly neutral pH provokes considerably less peritoneal irritation.

Differentiating Simple and Strangulating Obstructions

It is to be conceded freely there is no reliable way by which simple and strangulating obstruction can be uniformly differentiated save by operation. An item of special help in the differential diagnosis is the determined assumption by the patient of a position of relief from which posture the patient resents being moved—this circumstance, together with the presence of *intestinal colic* suggests very definitely the presence of strangulating obstruction. The patient will frequently lie on his side with his legs drawn up. When the house officer or nurse attempts to have him lie supine, he rejects the suggestion, saying often: "It has taken me a long time to find this position of relief and no one will drive me out of it." In my experience, this combination of circumstances indicates very definitely that operation is in order.

Pneumoperitoneum in the Recognition of Venous Strangulating Obstruction[2]

Inflation of air into the peritoneal cavity will serve to distinguish venous strangulating obstructions, in which the strangulated gut has attained increased density because of the effusion of blood and fluid into its wall and lumen. In arterial strangulation such as is occasioned by a plug in the superior mesenteric artery, there is no increased density of the obstructed bowel; in consequence, inflation of air into the peritoneal cavity would not be helpful in the diagnosis. The presence of such an obstruction can be verified preoperatively only by retrograde percutaneous placement of an inlying polyethylene tube through the femoral artery to the level of the twelfth thoracic aorta. Injection of diatrizoate (Hypaque) sodium and an abdominal scout film will serve to tell whether the superior mesenteric artery is patulous.

When the bowel is distended, surgeons worry naturally, over the hazard of introducing a needle into the peritoneal cavity.

Yet, it is far more important to recognize the presence of a strangulating obstruction than it is to overlook it. In fact, I have once observed penetration of the gut wall by a needle, introduced for the purpose of producing pneumoperitoneum, in the presence of an adherent bowel beneath. In this instance, after the polyethylene catheter was passed through the needle, the needle was withdrawn and the patient was taken directly to the operating room. Interestingly enough, there was no leakage around the needle. An enteric intussusception was uncovered which was very difficult of reduction. In other words, the presence of this untoward accident had succeeded in identifying the obstruction through the urgent necessity of dealing with the needle perforation in the gut wall. The patient convalesced uneventfully and has continued to do well.

Obviously, there is great need of simpler methods of differentiating sharply between simple and strangulating obstructions.

Review of Manifestations and Findings

In interrogating a patient, it is always best to talk with the patient in his own language—the vernacular. An excellent source of information is the charting of nurses, who register in an unprejudiced manner, without attempting to interpret the meaning thereof, what the patients tell them. The patient usually describes the distress of *intestinal colic* as 'gas pains.'

A patient with obstruction of the lower reaches of the small intestine usually has frequent, regurgitant vomiting, often copious in amount. It is brownish in color and feculent in odor. If the obstruction is simple in nature, abdominal tenderness is ordinarily absent; if strangulating in character, tenderness is often elicited.

If a patient has *intestinal colic,* no tenderness and no vomiting, and only gastric juice or bile is obtained by suction, applied to an indwelling duodenal tube, the likely diagnosis is obstruction of the colon occasioned by an obstructing cancer. If *intestinal colic* is accompanied by tenderness, and especially if the patient has back pain and has found a position of relief, he probably has a strangulating obstruction. The site of the obstruction can be determined fairly accurately by devoting care to these observations. X-ray films are, obviously, of great help in localizing the site of obstruction. Even with this help, it is not possible to tell just *how* the bowel is obstructed.

In colic obstruction, vomiting is usually absent. If vomiting does occur, it is invariably slight in amount and only gastric or bilious in nature. The look and the smell of the fluid aspirated from the stomach by the inlying duodenal tube can be very helpful. Thirty years ago it was accepted as axiomatic that feculent vomiting occurred with obstruction of the large bowel. I have yet to see it. Feculent, copious vomiting, in my experience, indicates the presence of obstruction of the small bowel. This difference in behavior of obstruction of the large and small intestine is owing to the behavior of the ileocecal valve mechanism, which behaves as a check valve, preventing reflux back into the ileum, once gas and fluid have made their way into the cecum.

Dennis (1944), while still a member of this Department, examined the x-ray films of a large number of patients with acute obstruction of the colon. In 77 per cent of instances only minimal participation in the distension by the lower reaches of the ileum was observed. In other words, in the majority of instances this check valve behavior of the ileocecal valve occurred as the normal situation in the obstruction of the colon. Moreover, as remarked above, I have yet to see feculent vomiting in the presence of obstruction of the colon. This is one barnacle which has been deleted from the bowel obstruction problem through the agency of more accurate observation.

Roentgenography

Scout films of the abdomen taken with the patient lying supine can give very important information on a number of points including the contour and topography of distended intestinal coils and the extent of the distension.

It has long been routine practice in my clinic to tape a nickel (five-cent piece) which measures 2 cm. in diameter to the umbilicus at the time the film is taken. The enlargement of the nickel, of course, will be greater than that of coils within the abdomen. Ordinarily, as films are conventionally taken with the patient lying supine, the nickel in this position will be enlarged 50 per cent; that is, it will measure 3 cm. in diameter. If it is strapped to a spinous process on the patient's back with the patient lying supine, there is little, if any, enlargement.

It is a useful and practical plan for the surgeon's orientation, concerning the true nature of the extent of the distension, to make measurements of the distended intestinal coils on the x-ray film, then to compare these measurements with those obtained at operation. My experience is that with the patient lying supine, the enlargement of the coils as later determined at operation is in the area of 25 to 33 per cent. The film taken with the patient lying prone is likely to give a truer reflection of the enlargement of the coils. Unfortunately, however, in a film taken with the patient in this position, it is impossible to trace out the continuity and contour of the distended coils. A film taken with the patient erect, sitting or standing is especially useful in obstructions of longer duration, in that the fluid which accumulates in consequence of decreased intestinal absorption shows distinctly on the film. This is because gas in the distended intestinal coils rises to the top of the obstructed loops and shows as gaseous shadows mirrored over the fluid levels.

On this score, it should be said the stethoscopic examination alone gives very valuable information. In acute gaseous distension, the borborygmi have a metallic tinkle; whereas when fluid is present within the distended coils significant of the presence of an obstruction of longer duration, gurgling can be heard, much in the manner of air entering and water running out of an inverted bottle. In fact, I believe in Wisconsin, this gurgling sound, so like that of the obstructed bowel with fluid retention, is heard frequently over the radio through the courtesy of a certain beer manufacturer.

In colic obstructions, the nickel on the umbilicus gives the surgeon very helpful and precise information as to just where the distended transverse colon is; this maneuver, therefore, is a very helpful guide in directing the surgeon where to place the *transverse* incision in doing a *transverse* colostomy in tapping the obstructed colon.

SPASTIC AND PARALYTIC ILEUS

The difficulty of differentiating sharply between spastic and mechanical ileus is a problem known to all of us. Moreover, in many of the distensions attending sympathetic nervous imbalance, features of both the spastic and the paretic varieties may occasionally overlap. Today, when sympathetic blocking agents are given frequently to patients for the relief of hypertension, it is necessary to be alert to the occurrence of ileus as a complication of that therapy. Patients arriving at hospital with abdominal pain and distension may have a paretic bowel, which may respond remarkably to treatment with an indwelling long intestinal tube.

My feeling is that if one cannot make a satisfactory diagnosis in a given situation, the surgeon would be well advised to operate. In the ultimate analysis, apart from the periodic thrusts of the peristaltic rushes, the end effects of paralytic and mechanical obstruction upon the bowel wall are much the same. In other words, great distension because of the increased intraluminal pressure, retards venous outflow. If it is long continued, it puts a strain upon the viability of the intestinal mucosa even though the observed pressures in the distended mechanically obstructed small intestine in such instances rarely exceeds 15 cm. of saline solution. In mechanical obstruction of the colon, on the contrary, pressures as high as 52 cm. of saline solution have been noted, on insertion of a needle into the bowel on completion of the colostomy. The end effects of paralytic ileus, save that attending peritonitis, are in many respects very much like that of a mechanical obstruction. Hence, in the presence of great distension of paretic origin, not relieved by conservative suction, more lives will be saved by operative decompression than by allowing great distension to go unrelieved for long periods of time. All the surgeon needs do at operation following insertion of a catheter or large needle into the bowel is to press upon the external abdominal wall with his hands. If the distension is entirely gaseous or fluid, an immediate and startling deflation occurs; it is the interspersion of gas and fluid in the distended intestinal coils that makes ready decompression difficult.

Use of Long Intestinal Tube With Coiled Spring[3]

The surgeons of my day will recall that when a duodenal tube was to be passed, a stylet was employed to lend the tube enough stiffness to permit its being passed through the mouth. At the distal end was a small rounded metallic bucket, into which the stylet fitted. When the tube reached the stomach, the stylet was withdrawn and the patient was placed in the right lateral decubitus position

with the hope that the tube would enter the duodenum. In 1921, Levine, of New Orleans, placed a urethral-like tip on the duodenal tube, thus making it possible to pass the tube into the stomach through the nose. With development of this expedient, the Einhorn bucket and stylet disappeared. Certainly those of us today who knew and used the old Einhorn tube and stylet are distinctly in the minority. Grafton Smith re-introduced the stylet in order to lend enough stiffness to his tube to permit its ready entry into the duodenum. Employing a controllable tip, which would permit it being flexed or extended, Smith found under fluoroscopic control he could intubate the duodenum in the majority of instances within a few minutes. Moreover, with a gentle thrust of the tube with the stylet in place, he could get the tube to the duodenojejunal angle a few minutes later. From there on, however, the descent of the tube was as slow as with other techniques. This stylet had to be well lubricated even to permit ready extrication from this position. In fact, it was Smith's practice to smear the tube well with Vaseline, held in gauze in his hand, before placing the stylet within the tube. If one passed the Smith tube at operation to decompress the distended bowel, one found it necessary to remove the stylet as soon as the tube reached the duodenojejunal juncture; otherwise, it would be impossible to extract it and it would become necessary to remove the entire tube and begin the intubation all over again.

After Grafton Smith left us to join the Department of Surgery at the University of Missouri (1956), our efforts directed at improvement in the design of long intestinal tubes to encourage their descent were temporarily laid aside. In 1957, the matter was again taken up in our experimental laboratories. A number of persons during these years (1957–1961) have worked on the project successively; Drs. Harlan Root, Peter Salmon, Ward Griffen, Demetre Nicoloff and Arnold Leonard have each lent impetus to the project. Our instrument maker, Mr. John Phelan, who has worked very closely with this Department over the past 25 years, has been very helpful in the effort. A number of years ago, Dr. Leo G. Rigler, then Professor of Roentgenology at the University of Minnesota, after discussing the matter with my instrument maker, John Phelan, had a coiled wire spring incorporated into the tube to facilitate following descent of such a tube on roentgen examination.[a,b,c]

When a coiled spring was incorporated into the long intestinal tube, it was found that withdrawal of the stylet constituted no problem. Employing this simple expedient, it has been possible to leave the stylet in place until the tube has reached the desired location. Whereas the method has been found useful in accelerating descent of the long tube, its greatest success has been in achieving ready descent of the tube at operation. The intubator standing at the head of the table, beside the anesthetist, continues to advance the tube slowly, after its course has been guided through the pylorus past the duodenojejunal angle by the hand of the tube. When the tube has reached the desired place, the stylet can easily be withdrawn.

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a. The following items from Doctor Rigler and Mr. Phelan, which refer to earlier use of a coiled spring in an intestinal tube, are of interest. In reply to a letter of inquiry, Doctor Rigler in a letter dated June 5, 1961, wrote me as follows:

> "We were anxious to make a tube which would permit us to put in a stylet and yet have the tube sufficiently flexible so that it would create no problem in passing it through the pylorus or around the various curves. It was necessary to get a tube which was noncollapsible; otherwise, we found it impossible to withdraw the stylet once we had gotten it into the desired position. This was the idea of having the spiral wire woven into the tube. The fact is that Dr. Hector Ducci had brought with him from Chile a tube of somewhat that type and it was this that led me to go to John Phelan to make a tube of that kind."

b. Mr. Phelan also wrote June 14, 1961, concerning use of a coiled spring in intestinal tubes:

> "I have been thinking about the question of use of the coiled spring in tubes for aspiration. The time referred to goes back to about 1939 or 1940 when I was suffering from a perforating duodenal ulcer and was using a tube to aspirate my stomach because of retention.* I found that the ordinary tube collapsed if I used an aspirator of the faucet type wherein water was the means of setting up the negative pressure. I still have one of those tubes which I designed and made without any knowledge of what had been used or conceived prior to that time.
>
> While working with Dr. Leo Rigler on another project not at all similar, I recognized that the tube which I had made for my own use might be helpful to him in some portions of his work. I pointed out to him that the coiled steel within the tube gave very good definition of the lie of the tube after it reached the stomach, as was later demonstrated under fluoroscopy and by x-ray films."

c.* A Billroth II three-quarter resection for Mr. Phelan's duodenal ulcer was performed by me on September 4, 1942. The operation left Mr. Phelan a little on the thin side but he has been very active and well these many years, as those who have used his services will agree.

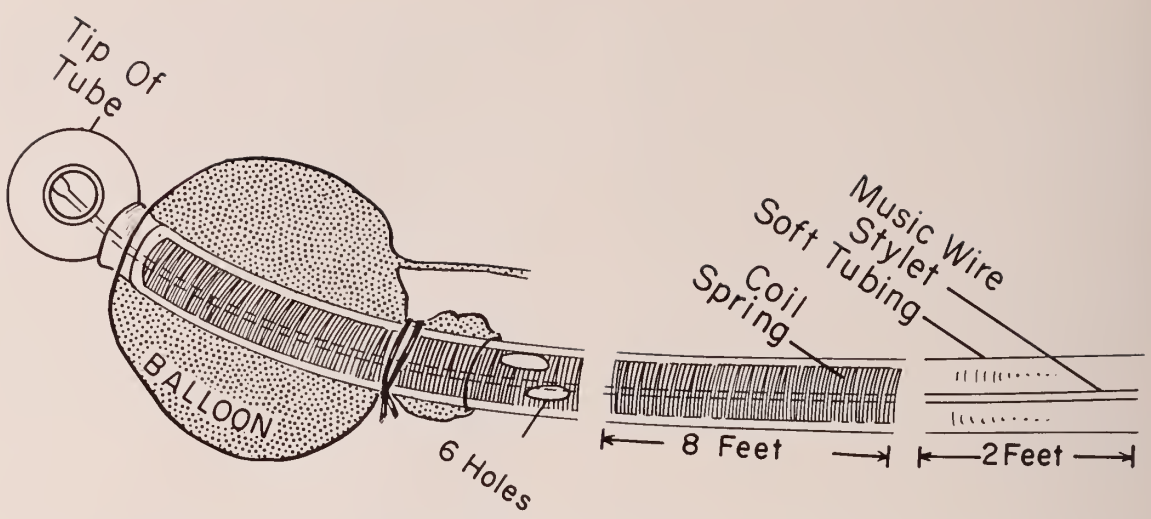

Fig. 1a—Diagram of long intestinal tube showing distol bucket of Einhorn voriety, the distal balloon and the coiled spring. The two proximol feet of tube, which would lie in the esophagus and pharynx, hove no coiled spring. The diagram also depicts the stylet used in passing the tube.

The coiled spring provides gentle curves in the tube, permitting ready withdrawal of the stylet. A brief description of the tube and its design, together with our experience with its use, was made recently.[3]

Additional Maneuver to Combat Postoperative Distension; Placement and Management of Soft Nosed, Balloon Tipped Catheter in Sigmoid Colon

The alimentary tract is a long canal with orifices at both ends. It can be intubated, therefore, from either direction. Placement of tubes in the rectum to facilitate evacuation of gas after operation in the presence of colic distension is a time honored procedure. However, those who have had experience in trying to pass a tube up into the lower reaches of the sigmoid colon at operation through the rectum know how frustrating the experience can be. More often than not, when the intubator passes the tube, it is almost a miracle to have the tube negotiate the flexures of the rectum by passing Houston's valves without being deflected by the valves, whereby the tip of the tube returns to the sender. Over a period of more than 30 years in this clinic, attempts have been made periodically to augment or encourage evacuation of gas from the colon by this method.

In the mid-twenties, I had an unusual experience with a few patients with so-called spastic ileus. Even prior to use of the inverted posture to indicate the extent of occlusion of the rectum in imperforate anus, (1930) I had tried a combination of the inverted posture and sigmoidoscopic placement of an Ewald tube to achieve decompression in two patients with intestinal colic and great distension of the colon in whom there was no demonstrable evidence of organic obstruction. The patients after being inverted and intubated were maintained in an upside down position for short periods of time. It was believed that gas would rise and be spontaneously evacuated by use of this maneuver. However, repeated attempts upon two patients did not prove rewarding and the effort was abandoned. In the mid-thirties, Dr. George S. Bergh, then a surgical fellow in this Department, made similar efforts to decompress instances of cancerous obstruction in the rectosigmoid area by intubation with an Ewald tube through the sigmoidoscope. In fact, some successes with the method were encountered. However, when the colon of one such patient perforated a few days later from the tip of the stiff Ewald tube having penetrated the bowel wall, efforts to decompress the obstructed colon in this manner were discontinued. In the intervening years, Bruusgaard (1947) described successful decompression in a large number of patients at the Ulleval Hospital in Oslo, for gaseous distension of sigmoid volvulus by a tube introduced through a sigmoidoscope, a method that has now been adopted universally.

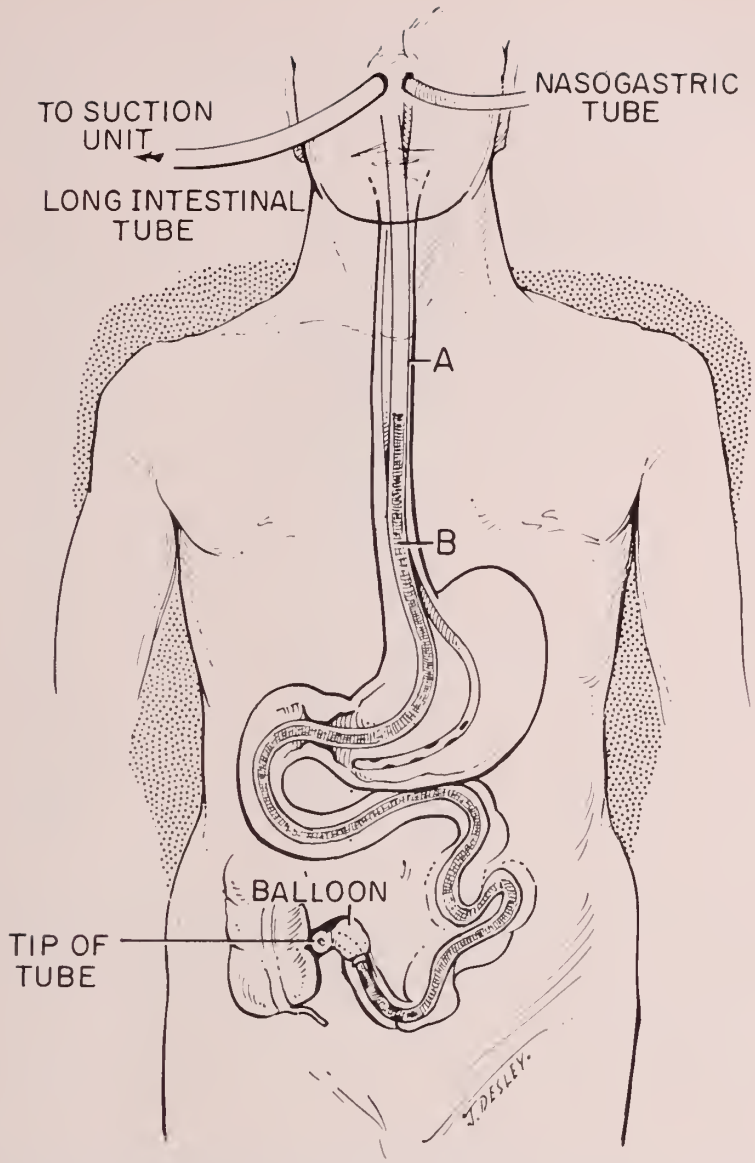

Fig. 1b—Schematic drawing shawing long intestinal tube in place. There is olso an ordinary duodenal tube in the stomach.

During the past few months, we have begun to reassess rectal intubation in postoperative patients at the time of operation. The simplest technique seems to be to pass a (No. 24 F) Foley urethral catheter[a] with the aid of a stylet or catheter guide at operation. The usual difficulty referred to above with Houston's mucosal valves is thereby circumvented. When the tube has entered the iliac portion of the pelvic colon, the surgeon guides it into the sigmoid flexure. The stylet is withdrawn and the balloon (30 cc.) is distended with water to a comfortable state of fullness, depending upon the diameter of the bowel. Placement of a fine suture of plain catgut (00000) below the distended balloon and through the mesentery at this level, tied loosely with no suggestion of compression upon the bowel wall, serves to maintain the inlying colic catheter in position, restraining it from being ejected. Moreover, this technique is also employed in low colic or rectal anastomoses. In cecoproctostomy the balloon tipped catheter can be passed into the ileum through the ileocecal valve.

If a soft catheter is introduced and left in place, without being retained by such a stitch, it is not unusual to find the catheter

a. The No. 24 Foley catheter has a short stubnosed tip and the balloon inflates symmetrically and concentrically.

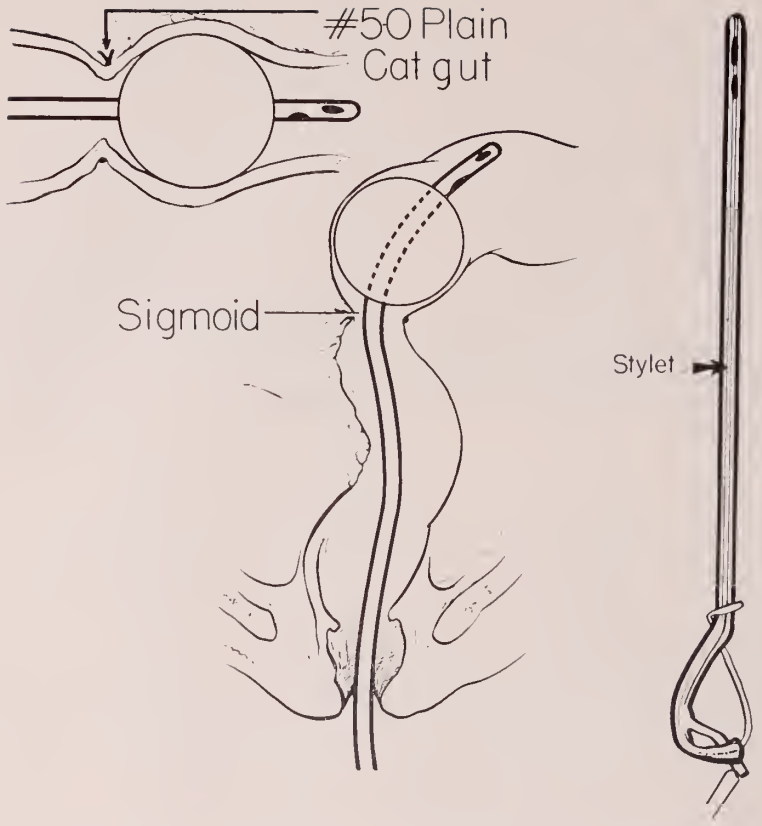

Fig. 2—Sketch illustrating placement at operation of No. 24 Foley catheter into sigmoid colan. The use af a catheter guide makes it a very simple procedure to pass the tube up through the rectum withaut encauntering difficulty fram Houston's valves. The balloon (30 cc.) is inflated with water to a size camfortably adjusted to the diameter of the bowel. A No. 5 (00000) plain catgut stitch is passed thraugh the mesentery and is tied gently without campressing the bawel inferiar ta the balloon.

This tube alsa can serve as a means of administering same of the pastaperative fluids during the recovery stage thus minimizing the need for intravenaus administration.

upon the operating table, already having been evacuated by the time the operation has been completed. If a stiff tube such as the Ewald is used, the complication of perforation of the bowel wall, referred to above, makes it a hazardous procedure.

In many respects, postoperative ileus may be regarded as partaking of the elements of inhibitive as well as spastic ileus. With a soft tube lying within the sigmoid colon, to which suction can be applied, it should not be too difficult to deal with colic gaseous distension by this method. In fact, the so-called postoperative distension in certain respects may be looked upon as being mechanical in nature, made so in part by the flexures of the colon and the rectosigmoid area.

It would appear from a brief experience that this device is a useful expedient to combat the development of postoperative distension. Enough preliminary skirmishes with the method already have been made to suggest it has real promise. In fact, the tube has also been used for administration of fluids postoperatively, thus lessening the necessity for intravenous infusions.

Cervical Esophagostomy for an Inlying Duodenal Tube for Suction or Feeding

Though sensitive to complaints of the patient concerning an inlying duodenal tube in his throat, I do not share the serious misgivings that some surgeons entertain over this. As most of you know, in recent years many surgeons have resorted to the technique of making a gastrostomy to avoid use of the intranasally placed inlying duodenal

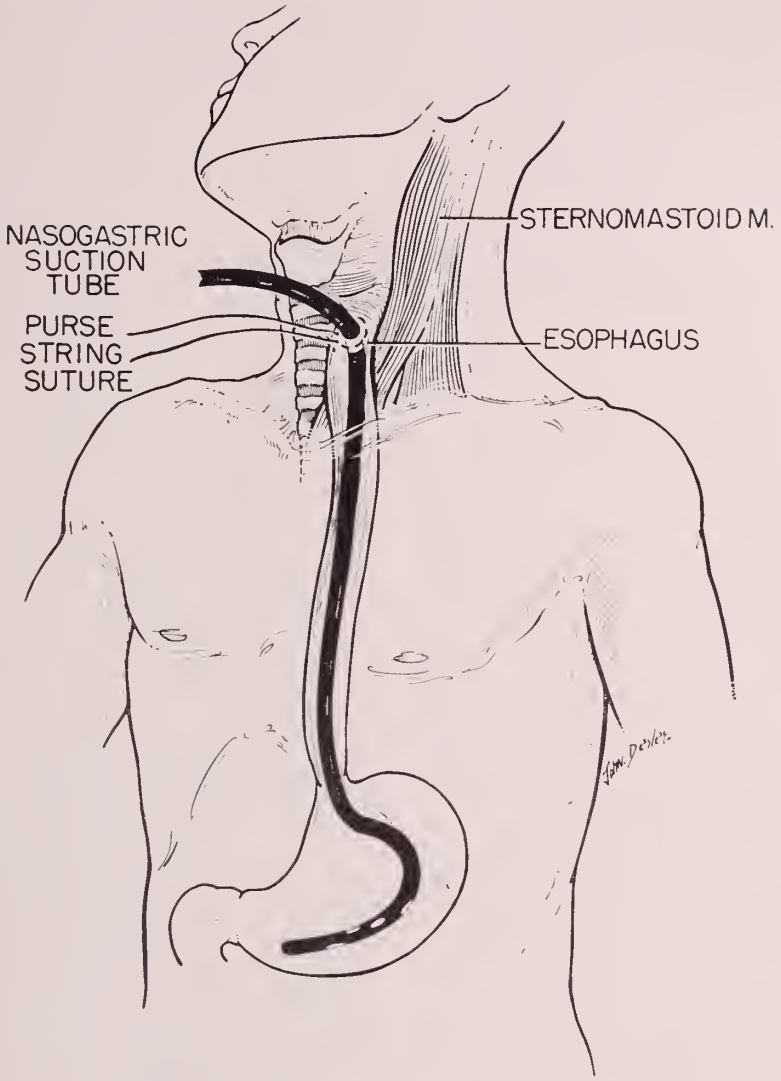

Fig. 3—Placement of a cervical esophagostomy catheter for suction or feeding. When it is known that an inlying gastric tube must be kept in situ for a long time, this device constitutes an effective manner for suction or feeding.

tube. In the experimental laboratory a duodenal tube has been introduced into the stomach of many dogs through the cervical esophagus both to evaluate use of such a method for purposes of suction as well as feeding. In no instance has mediastinitis or an esophageal fistula developed. It may well prove that this simple device could be used in man, too. In fact, in a patient somewhat intolerant of an inlying feeding tube (nasal) because of fever, the nasogastric tube was replaced by a similar tube inserted through the cervical esophagus. At operation, the sternal head of the sternocleidomastoid muscle was detached and placed beneath the esophagus. This patient, who has a palatal paralysis and in consequence swallows poorly as a result of a cerebrovascular accident, has been fed via such a tube for months. No evidence of an esophageal leak occurred and her general condition has improved considerably meanwhile.[a]

Hypnotic Suggestion, Tubes and Needles[4]

I recalled the complaint of a patient concerning his inlying duodenal tube during convalescence for an operation for regional enteritis when he returned a number of years later for a second operation for recurrent

a. After a year, the patient still takes her feedings through this tube.

regional ileitis. This led me to inquire of the patient as he left the hospital: why on the latter admission the duodenal tube had apparently not bothered him. To my inquiry he replied: "I went to the dentist who pulls my teeth under hypnotherapy and asked 'Can you pretreat me for Wangensteen?'" His dental surgeon, Dr. Aaron Papermaster of Fargo, North Dakota, undertook to explore its utility for us in the management of surgical patients. In the instance of the patient referred to above, Doctor Papermaster had focused primarily on urging acceptance of the postoperative state, including the presence of indwelling tubes and needles for intravenous infusions. Obviously, Doctor Papermaster had done his job well for on this latter admission, the patient *swore by* the things he had *sworn at* in his earlier hospital admission. As many of you probably know, hypnotherapy has come to be an important therapeutic device in our clinic to encourage acceptance of the postoperative state, for the alleviation of pain, for the acceptance of proctoscopy, to encourage and facilitate spontaneous urination in elderly male patients after operation, and for a number of other trying situations.

In other words, hypnotherapy has been very useful in persuading the patient that the indwelling tube is not such a heavy cross for him to bear.

Fluids and Electrolytes

The vomiting attending obstruction of the small bowel is often copious in amount. Electrolyte losses and dehydration are therefore usual. The administration of 0.9% saline in a 5% dextrose solution should be started directly.

The best guide to the amount of fluid to be given is the specific gravity of the urine. If the density of the urine exceeds 1.024, the patient is dehydrated. The daily urine output should be as carefully charted as the patient's temperature. My practice has been to insist on the administration of enough parenteral fluid to insure a minimum daily urinary output in adults of about 1,000 cc. with a specific gravity of less than 1.020. For the severely dehydrated patients, four to six litres of fluid usually need to be given before a semblance of normal hydration is restored. In infants in whom the collection of urine may not be accomplished as easily, the wetting of diapers, turgor of the skin, and more general considerations can give helpful information relative to the amount of fluid needed.

The gastric juice and intestinal contents have a higher concentration of potassium than the blood. However, it is not wise to give potassium until enough fluid has been given to establish the presence of a good urinary flow. It would scarcely seem necessary to utter the warning that, with the employment of suction in the treatment of stasis in the gastrointestinal canal, it is particularly important to be alert concerning fluid and electrolyte losses and needs.

It is in high obstructions particularly that hypochloremia, hyponatremia and hypokaliemia are observed to accompany the dehydration of vomiting. In the presence of a good urinary output, approximately 3 gm. of potassium chloride (40 mEq.) should be given daily when the patient is being sustained on intravenous fluid. Losses of potassium through suction applied to indwelling duodenal or intestinal tubes may be as high as 32.5 mEq./l.—a value six times the value of potassium in a litre of plasma.

Because the body stores of glycogen from which glucose is mobilized are quickly depleted in starvation, it is a good plan to give enough glucose, in a 10 per cent solution, to provide 1,200 to 1,500 calories. As the initial dehydration is repaired by the liberal administration of saline solution, and as potassium losses are repaired by the administration of potassium chloride, it is wise to alternate the infusion of glucose in saline solution and distilled water. The continued administration of saline solution beyond the period when the obstruction has been relieved and fluid and electrolyte losses are no longer great, leads to retention of sodium with resultant retention of water and edema.

SUMMARY

The past three decades have witnessed important improvements and new techniques in dealing with the bowel obstruction problem. Moreover, the accomplishment also is far better today than it was 30 years ago. The forbidding mortality of acute intestinal obstruction of that day has been replaced by one which in experienced hands hovers today around 10 per cent. The objective of surgeons is to be able to deal with the trying problem of acute intestinal obstruction, as though distension did not exist. A sea of dis-

tended unruly bowel does, of course, make an important difference. Techniques directed at dealing with the problem of distension should make that hope and dream of surgeons come closer to reality.

Three items which contribute largely to the existent mortality in acute intestinal obstruction are: (1) the great technical difficulties of dealing with neonatal obstructions; (2) strangulating obstructions necessitating resection, and (3) great intestinal distension. Were it not for these factors, the mortality of acute intestinal obstruction today would be approximately that of dealing with the primary condition which caused the obstruction.

The use of the long intestinal tube with a coiled inner spring, which makes it possible for the surgeon at operation to pass the tube quickly into the lower reaches of the bowel without resorting to enterostomy or enterotomy for purposes of decompression, is described.

Two additional techniques are described which can be of help to the surgeon in combatting postoperative intestinal distension:

(1) Placement at operation of an inlying tube through the rectum into the mid reaches of the sigmoid colon to lessen postoperative distension. This catheter has a soft nose and an inflatable balloon at the tip. Placement of a fine catgut stitch behind the distended balloon insures its retention, until deflation of the balloon permits its expulsion. Moreover, distension of the colon by the balloon probably serves to hasten reestablishment of intestinal contractions following operation. Postoperative fluids also can be administered through this tube. This device also can be employed to supplant use of ancillary decompressive vents on low colic anastomoses.

(2) Placement of an inlying cervical esophagostomy catheter for purposes of suction or feeding, when it is known that the inlying intestinal tube must be kept for a long period of time.

All three of these techniques may prove to have value for the surgeon in thwarting the development of intestinal distension as well as in dealing with the problem of intestinal distension when it has occurred.

The diagnostic criteria upon which the diagnosis of obstruction can be made also have been outlined.

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DILEMMAS OF CLINICAL SURGERY

(continued from page 155)

the right reason; and I, for one, am happy to acknowledge my debt to the radiologists and internists who have told me where to cut and what to look for; and, especially, for the times they kept me from operating at all.

This list of surgical dilemmas presents a list of extremes—a black and white collection of the art and science of surgery. Good surgery for the patient must include both—as members of a specialist society, I would urge you more toward the science than the art.

May we carry with us a pride in our craft tempered by the humility so aptly put by Ambroise Paré when he said, "I dressed their wounds and God healed them."

123 North Military Avenue.

Clinical Significance of Prolapsed Hypertrophied Gastric Mucosa

By LOUIS OLSMAN, M.D.

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IN THE COURSE of our practice, we have found a number of patients with a variety of symptoms referable to the upper gastrointestinal tract, whose positive findings are limited chiefly to an x-ray report of prolapsed hypertrophied gastric mucosa. This entity is seldom mentioned in the standard texts on gastroenterology, internal medicine and general surgery. After seeing several of these patients within a short time, we reviewed the literature in an effort to determine the clinical significance of this condition and then reviewed the records of the two hospitals in our city to see how frequently it was reported and how it was being treated.

The initial description of this finding was made in Germany in 1911 by Schmieden.[1] In 1926, Eliason, Pendergrass and Wright[2] published the first description and discussion in the American literature. A report by Meyer and Singer[3] of Cook County Hospital followed in 1931. By 1937, Rees[4] found 12 cases in the literature. Melamed and Hiller, in 1943,[5] and others reported series of cases in which this finding was present and felt to be clinically significant; and, in the opinion of some investigators, required surgical intervention in certain selected cases.

Reports of incidence vary from 0.1% to 7.7%[6] and in one series, as high as 15.5%.[7] Since these statistics are all based on x-ray studies done on patients referred to the roentgenologist because of gastrointestinal symptoms, we do not feel that they reflect the true incidence. When Sherman and Snyder[8] of Memorial Hospital in New York recently reported results of gastrointestinal x-ray studies on 31,895 patients with no gastrointestinal symptoms, we wrote Doctor Sherman and asked him if he had recorded the incidence of prolapsed gastric mucosa in this series. This had not been done, but he agreed to survey his films for this condition.[9]

Five 70 mm. photofluorographic films were made of each patient. Five thousand patient examinations were serially reviewed by a member of the resident staff. Sixty-seven cases were found which showed even the slightest suggestion of prolapsed gastric mucosa. These 67 cases were independently reviewed by four staff roentgenologists. There was a difference of opinion in the number of cases definitely diagnosed as prolapsed gastric mucosa varying from 0 to 10 and in the number of probable cases from 5 to 19. It is Doctor Sherman's personal opinion that there was no example of severe or classical prolapsed gastric mucosa in the entire series of 5,000 cases. Even taking into consideration

Fig. 1—Normol pylorus ond bulb.

Presented before the Wisconsin Surgical Society at the 120th annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 4, 1961.

the inherent shortcomings of this type of screening procedure, it is evident that in patients with no gastrointestinal symptoms the incidence of prolapsed gastric mucosa is extremely small.

Discussion with radiologists at our local hospitals has revealed a divergence of opinion relative to the significance of this finding, and some have stated that they hesitate to report it unless it is accompanied by retention and obstruction. It is therefore obvious that any discussion of the statistical incidence of this condition is influenced by so many variables as to be totally inconclusive. It is also interesting to note that at autopsy, in a series of 1,500 consecutive cases where the pathologist was searching specifically for anatomical evidence of this lesion, he was unable to demonstrate a single one.[6]

The etiology and pathologic physiology has been reported repeatedly and we will mention it only briefly here, quoting Bartels and Eltorm:[10] "In the prepyloric area, between the glandular layer and the muscularis, there is a very thick submucous layer of loose connective tissue, loosely attached. Therefore the mucosa moves easily on the muscularis. Beyond the pyloric valve, the mucosa is firmly attached to the muscularis because of Brunner's glands which totally fill in the submucosa and is thus fixed in this area." Thus any condition which will produce thickening, edema, congestion or hypertrophy of the mucosa, such as gastritis, portal cirrhosis, protein deficiency edema, chronic cardiac decompensation, or any factor producing increased gastric motility, will predispose towards prolapse of the mucosa. Gastritis with ulcer may result in prolapse; the ulcer may heal but the prolapse may persist. It is interesting to note that in cases of gastric ulcer with hypomotility, prolapsed gastric mucosa rarely co-exists.

Gross anatomic findings at surgery or autopsy will vary from completely negative to those of associated gastritis, pyloric atrophy or hypertrophy, or constriction of the pyloric channel.

Symptoms are generally those of gastritis and ulcer, including epigastric pain, nausea, belching, vomiting and gastric bleeding. Frequently, the pain is not relieved by alkalis and may be initiated by food ingestion instead of being relieved by it. Symptoms may be aggravated by the recumbent position; and the patient may be afraid to eat for fear of initiating nausea, vomiting and pain. Distress may have a sudden onset, rapid relief, and there may be complete freedom from pain between attacks. In the absence of ulcer,

Fig. 2—Prolapsed hypertrophied gastric mucosa.

Fig. 3—Prolapsed hypertrophied gastric mucosa.

food aggravation of pain (rather than food relief) is more or less characteristic of prolapsed gastric mucosa. Bleeding may be minimal and limited to the presence of occult blood in the stool or there may be massive gastric hemorrhage. Secondary anemia is a frequent finding, and in one series, was present in 68% of the cases.[11]

There is often a marked disproportion between the severity of the symptoms and the degree of x-ray findings. The x-ray findings are typical and consist of a mushroom shaped defect of duodenal bulb, and narrow radiating folds into base of bulb. (Fig. 1, 2, and 3) Acid values are not characteristic and offer very little aid in diagnosis. Gastroscopy is of limited value.

Management requires a prolonged trial of medical therapy with special efforts made to correct accompanying gastrointestinal lesions which may be contributing to the symptoms. The classical peptic ulcer regimen is followed, including diet, antacids, anticholinergics, and tranquilizers. Psychiatric evaluation and therapy should be included when indicated. If, despite all of these measures, the symptoms persist, then, and only then, should surgery be considered.

In the early reports of surgery for this condition, in the 1930's and the 1940's, operation consisted of wedge-shaped resection of segments of the hypertrophic mucosa, pyloroplasty and/or gastroenterostomy. These were not generally satisfactory; and as subtotal gastric resection became more widely used for surgery in duodenal ulcer, this also became the procedure of choice for prolapsed hypertrophied mucosa.[4, 7, 8, 12, 13, 14]

In general, surgery is reserved for the patients with intractible pain, chronic obstruction or persistent bleeding.[15] Surgery is contraindicated in patients where hypertrophy is secondary to portal cirrhosis, cardiac decompensation or hypoproteinemia.[16] Those patients with a strong psychiatric overlay must be screened most carefully before being subjected to surgery.

In 1959, Spencer[17] polled a number of prominent surgeons and internists concerning their attitude on using surgical therapy for this condition. These men included Dragstedt of the University of Chicago, Waugh of Mayo Clinic, Renshaw at the University of Colorado, Palmer and Kirsner of the University of Chicago, McHardy of Tulane University, and Collins from the Cleveland Clinic. The surgeons were unanimous in stating that they had never operated on a patient where prolapsed hypertrophic gastric mucosa was the only indication for surgery. The internists were all quite hesitant to ascribe the symptoms of these patients to this entity alone, although they agreed to the relative frequency of the findings on x-ray. Bockus,[18] in his textbook, *Gastroenterology,* states that prolapse of the gastric mucosa is a rare cause of gastric symptoms. Barborka, in Christopher's *Textbook of Surgery,*[19] states: "There is a considerable difference of opinion as to whether this condition produces symptoms and what treatment is to be used. Many workers feel that it is a physiological variant, being seen as often in patients without symptoms as those with symptoms. Only severe intractible cases should be operated."

TABLE 1—*Distribution of prolapsed gastric mucosa during a five-year period*

Age	Male	Female	Total
1–20	1	0	1
21–30	6	2	8
31–40	9	0	9
41–50	13	3	16
51–60	11	5	16
61–70	7	2	9
71–80	3	0	3
81–90	2	0	2
TOTAL	52	12	64

TABLE 2—*Symptoms of prolapsed gastric mucosa during a five-year period*

Symptoms	Prolapsed Gastric Mucosa Only	Prolapsed Gastric Mucosa with other Gastrointestinal Pathology*	Total
Pain only	13	14	27
Pain + Bleeding	1	2	3
Pain + Obstruction	8	7	15
Pain + Bleeding + Obstruction	3	1	4
Bleeding Only	1	5	6
Bleeding + Obstruction	0	2	2
Obstruction only	0	3	3
No symptoms	1	3	4
TOTAL	27	37	64

*Other gastrointestinal pathology included hiatus hernia, gastric hypermotility, antral gastritis, pylorospasm, duodenal ulcer, duodenal diverticulum, diverticulosis of the colon, history of proven ulcer despite current negative x-ray films, gallbladder disease or prior cholecystectomy.

In our city, we were able to find 64 cases in the hospital files over a five-year period. (Table 1). Surgery was performed in only one case.

Table 2 indicates that it is most difficult to evaluate and correlate severity of symptoms with the findings on x-ray and to determine what part of the symptoms are due to as-

sociated gastric, colon, or gallbladder pathology.

The following case report shows some of the problems of management of this condition.

CASE REPORT

A 32-year-old white laborer presented primarily complaints of epigastric pain, belching, bloating and sensation of abdominal fullness, and on several occasions, hematemesis. Repeated gastrointestinal x-ray studies revealed a small hiatus hernia, prolapsed gastric mucosa, and diffuse diverticulosis of the colon. The patient also had an umbilical hernia which was small, incarcerated, and tender. After a year of medical management without any consistent improvement, repair of the umbilical hernia was performed. The patient's symptoms were not materially changed. He was very cooperative and followed instructions quite well.

He was again hospitalized and the same x-ray findings were present. Gastric analysis before and after the alcohol test meal revealed the following:

	Free HCl	Combined HCl
Fasting	30°	52°
½ hour	38°	49°
One hour	38°	54°

The patient was most insistent that something be done. After another trial of medical management with no improvement, a subtotal gastrectomy was performed. The gastric antrum appeared to be somewhat thickened. The pathologists' report was that of catarrhal gastritis and muscular hypertrophy of the outlet. Postoperatively, the patient was unable to tolerate clamping off of the nasogastric tube after the fifth day and began to show evidence of gradually increasing obstruction at or just distal to the anastomosis. A thin barium swallow confirmed this. On the fifteenth postoperative day, laparotomy was performed. A loop of ileum was found to have become adherent to the area of anastomosis and obstructed. It was necessary to resect four inches of ileum. In order to examine the anastomosis, a jejunotomy was done distally and a finger passed into the gastric remnant. The anastomosis was found to be patent and adequate, thereupon the jejunotomy was closed and a Witzel jejunostomy performed. The patient made a good recovery but developed a postoperative hernia which was subsequently repaired. At present, the patient is working steadily as a laborer and is asypmtomatic except for an occasional episode of lower left quadrant abdominal pain which is attributed to his sigmoid diverticulosis.

One other case, not included in the current series since it antedated our studies, but which also shows some of the problems of surgical management, warrants brief mention. This was a 58-year-old white man, a patient of a colleague, who complained of intermittent severe epigastric pain with belching and no relief from milk, food, or alkalis. The patient was sent to a Veterans Administration hospital where he underwent surgery. Findings at surgery were those of a large amount of redundant mucosa falling into the pylorus producing an obstruction. A large portion of the redundant mucosa was excised and a pyloroplasty performed. Postoperatively, the patient's course was characterized by a long period of pyloric obstruction which improved gradually. The patient was re-admitted three months later with evidence of continued pyloric obstruction. X-ray studies revealed 50% gastric retention. At this time a subtotal gastric resection was done from which the patient made an uneventful recovery. Fourteen years later his local physician reported no gastrointestinal complaints.

SUMMARY

The finding of prolapsed gastric mucosa has been acknowledged to be a definite x-ray entity, and in the opinion of many observers, one of clinical significance. The great majority of cases will respond to medical measures. Those to be subjected to surgery must be most carefully observed and all other possible causes of the symptoms ruled out or corrected. Operation should be a subtotal gastric resection, since anything less radical will generally give unsatisfactory results.

625 57th Street.

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Intermittent Pyloric Obstruction Due to Prolapse of an Inflammatory Fibroid Polyp of the Stomach

By K. E. SAUTER, M.D., and B. J. PESSIN, M.D.

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IN RECENT years more attention has been focused on benign gastric lesions because of increased and more accurate roentgenological examinations and because of their malignant potential.

Since Vanek's description[1] of the eosinophilic granuloma in 1949, this relatively new lesion has been reported with increased frequency.

The following is a case report of one of these lesions and a discussion of its interesting and unusual features.

CASE REPORT

A 59-year-old white woman entered the hospital complaining of repeated attacks of epigastric distress for three months. These were accompanied by vertigo, palpitation, and a vise-like sensation in the epigastrium. The latter was described as a cramp-like gas pain, which disappeared after a few minutes. On two occasions these attacks resulted in weakness, vomiting, and syncope. The appetite, otherwise, was good, and the patient denied weight loss. The stools were black because of previous iron therapy, presumably given for secondary anemia. There was no diarrhea or constipation. She also complained of moderate dyspnea and palpitation on exertion. In 1946 she had a herniorrhaphy and hemorrhoidectomy, and in 1953 a rectal polypectomy.

She was well nourished and well developed but appeared pale. Her temperature was 99.6 F., pulse 78, blood pressure 124/64. The abdomen was flat and nontender. There was an 8 × 8 cm. soft, smooth, nontender mass, slightly to the right of the epigastrium. The mass did not move on palpation or respiration. She had black stool in the rectum and 1+ pedal edema. The previously described mass could not be consistently found by one of the authors on successive days. Her erythrocyte count was 2.36 million, hemoglobin 6.5 gm. per 100 ml., color index 0.91, leukocyte count 4,850, sedimentation rate 10 mm., fasting blood sugar 148 mg. per 100 ml., bilirubin 0.125 mg. per 100 ml. direct, and 0.7 mg. per 100 ml. indirect. Urinalysis was negative. There was no free hydrochloric acid in the gastric contents and the total acid was 33 at the end of two hours.

ROENTGEN REPORT

The stomach was grossly distorted in the dependent portion, including the pars media and antrum, and had irregular filling defects. Barium outlined this area and a mass was felt. No barium was seen passing through the duodenal bulb; however, on examination of the delayed films it was found that barium did enter the duodenal bulb and proximal small bowel. The mucosal relief air pattern of the duodenal bulb had the appearance of extrinsic pressure. *Impression:* Large midabdominal polypoid mass which could be a tumor of the head of the pancreas with pressure on the duodenal limb and invasion of the stomach, or a primary carcinoma or lymphosarcoma of the stomach with extra gastric extension. (Fig. 1).

On celiotomy, a large tumor mass was palpated in the distal end of the stomach. This mass could be moved freely and slipped in and out of the first part of the duodenum without difficulty. The pylorus and duodenum were greatly dilated. The serosal surface of the stomach at the antral end had a hard nodule which was presumed to be a neoplas-

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Fig. 1—Progress film showing appearance of stomach two haurs after upper gastrointestinal fluaroscopy.

tic extension. Many enlarged, soft, lymph nodes were scattered throughout the omentum and gastrohepatic ligament. A subtotal gastric resection and anterior gastrojejunostomy was performed. The clinical impression was probable lymphosarcoma. (Fig. 2).

PATHOLOGY REPORT

Gross Examination: Specimen consisted of approximately one-half of the stomach with a portion of omentum. The specimen was 22 cm. along the greater curvature and 11.5 cm. along the lesser curvature. The serosa was thickened and in one area there was a cone-shaped depression where the serosa was white and thickened; parallel lines radiated from the periphery towards the center of the depression. This depression was on the posterior wall midway between the greater and lesser curvatures and indicated a traction effect. Three small fibrous serosal nodules were seen along the lesser curvature which was 0.5 to 1.0 cm. in diameter. Upon manipulating the specimen, a freely movable pedunculated tumor protruded through the pyloric opening. The apex of the tumor was

Fig. 2—Gross specimen at surgery. Stomach opened showing polypoid mass.

9 cm. beyond the pyloric sphincter. The pedunculated mass was somewhat flattened, 19.5 cm. in length, 6.0 to 9.0 cm. in width and from 1.5 to 3.0 cm. in thickness. (Fig. 2). It had a broad base 6.0 by 3.0 cm. and arose from the posterior surface of the stomach. The surface of the tumor was granular, had a somewhat rugal and mosaic pattern. In the apex of the tumor were two ulcers, the largest of which was 2.4 by 1.2 cm. The remaining gastric mucosa was thickened, hyperemic and contained prominent rugae. The omentum contained many lymph nodes from 0.4 to 1.8 cm. in diameter. The lymph nodes were soft, grayish-pink and had no gross evidence of neoplastic involvement.

Microscopic Examination: The mucosa lining the tumor varied in thickness. The thicker portions were not unlike the changes seen in so-called chronic hypertrophic gastritis. The mucosa was markedly infiltrated with plasma cells among which were lymphocytes, polymorphonuclear neutrophils and eosinphils. The thinner portions had similar inflammatory cellular infiltrates and intramucosal fibrosis. The ulcerated portions consisted of cellular granulation tissue predominated by lymphocytes and plasma cells with a sprinkling of eosinophils. The muscularis mucosa was absent in the ulcerated areas and beneath the thin mucosa. Elsewhere the muscularis mucosa was markedly hypertrophied and extensively distorted. Isolated and small groups of broad smooth muscle fibers were widely separated by proliferating fibrous tissue. An occasional smooth muscle fibre was seen within the intramucosal areas of fibrosis. The greater bulk of the tumor consisted of marked to moderate cellular fibrous tissue infiltrated with lymphocytes, plasma cells and eosinophils. (Fig. 3). The fibrous tissue for the most part was edematous. The fibrocytic nuclei were quite large, ovoid to elongated, vesicular. Some contained prominent nucleoli. A very occasional mitotic figure was seen. This fibrous granulation tissue was vascular in places and everywhere in-

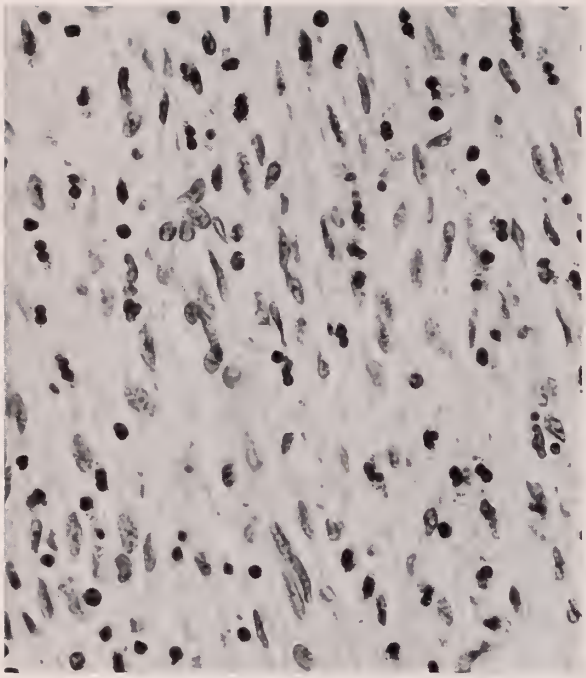

Fig. 3—High magnification of the fibrous granulotion predominontly composed of fibrocytes with sprinkling of eosinophils and lymphocytes (in some sections many more eosinophils and lymphocytes were present thon in the above illustrotion).

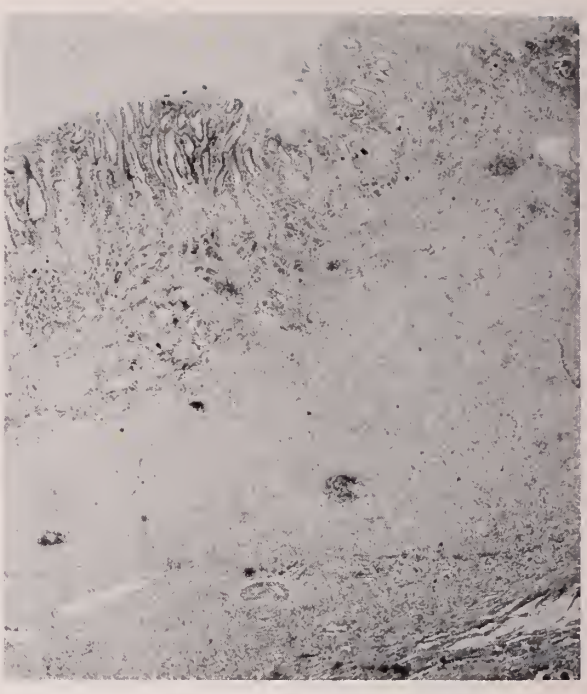

Fig. 4—Portion of inflammatory fibroid gostric polyp showing overlying thick and thin mucoso and underlying fibrous granulotion tissue.

filtrated with inflammatory cellular elements. In some areas the inflammatory cells were predominantly eosinophils and in other areas lymphocytes. Dense aggregates of lymphocytes were encountered beneath the mucosa. Plasma cells were abundant in places. One of the sections had a large area of lymphangiectasia. The arteries beneath the ulcers had thickening of the media and intima. Many veins were dilated and filled with erythrocytes. Some of the large rugae overlying the polyp were merely an extension of the fibrous granulation tissue covered by thick mucosa. Elsewhere the mucosa of the stomach had the changes seen in hypertrophic gastritis.

The chief characteristic of this massive polyp was a core composed of a cellular inflammatory fibrous granulation tissue covered by a well-differentiated mucosa of varying thickness. (Fig. 4).

DISCUSSION

INCIDENCE

Higgins,[2] in an autopsy study, found the incidence of benign polypoid gastric tumors to be between 0.15 and 0.8%. Vanek[1] reported an incidence of 0.36 in a series of 14,620 autopsies. Berg[3] reported 13 cases in 300,000 admissions at the Jefferson Hospital in Philadelphia, and 17 cases in 250,000 admissions to the Cleveland Clinic.

Actually, the incidence probably depends upon how painstaking a search is made for small nodules in the autopsy room. Meissner,[4] by careful examination of 50 autopsies chosen at random, found 44 very small leiomyomas in 23 stomachs. The relative proportion of benign and malignant tumors which make up the neoplasms of the stomach varies, but the average of several series reported by Kiefer and Christiansen[5] is one benign to 50 malignant tumors. An exception to this is a series reported by Rigler[6] who found 22% benign lesions in 239 neoplasms of the stomach.

The actual malignancy rate in so-called benign tumors is controversial. Berg,[3] reporting on 106 gastric adenomas, found that 13% showed transition to invasive carcinoma, 65% contained some degree of cellular atypia, and 95% showed more than one focus of proliferation. Hay[7] reported one out of 81 gastric tumors less than 2 cm. in diameter was malignant and 6 out of 14 lesions over 2 cm. were malignant.

The term eosinophilic granuloma was first popularized by Vanek[1] who reported three

cases in 1949. Actually, prior reference must be credited to Kaijser,[8] in 1937 and Herrera,[9] in 1948. Disagreement as to the proper designation of this lesion has been made by Helwig and Ranier,[10] and others. These authors have preferred the term inflammatory fibroid polyps in order to avoid confusion with eosinophilic granuloma of bone to which they bear no resemblance pathologically. Other terms variously used to describe this lesion are hemangioendothelioma, neurofibroma, hemangiopericytoma, polypoid fibroma, and fibrinous polyp.

PATHOLOGY

It has been pointed out that there are two varieties of this condition as noted by Ferrier and Davies,[11] and Barrie and Anderson.[12] One is the localized type and the other the diffuse type. In the diffuse type, the thickening of the stomach becomes more pronounced towards the pylorus where it often produces stenosis. The lesion in the duodenum or jejunum may resemble regional ileitis. Histologically the thickening is in the submucosa or lamina propria and the muscle coats. The characteristic features are the presence of large numbers of eosinophils. In addition, there may be hypertrophy of the muscular layer.

In the localized type, the majority are located in the pyloric antrum region of the stomach. Generally, they arise from the submucosal region, although some involve the deeper layers of the mucosa. The base is usually located above the muscularis mucosa. Some are sessile, others pedunculated. Superficial ulceration is common resulting in gastrointestinal bleeding and secondary anemia.

Microscopically, these lesions are characterized by fibroblastic, reticular or fibrillar connective tissue. Interspersed are blood vessels with variable size and mural thickness. Inflammatory cell infiltration is prominent with eosinophilic leukocytes usually predominating.

SPECIAL FEATURES

A classification of prolapse and gastroduodenal intussusception has been described by Hobbs and Cohen[13] and Eliason et al.[14] These authors list the possibilities as complete or partial, depending upon whether the entire thickness of the stomach wall or only the mucosa of the tumor is involved. They further classify them as central or lateral, and in addition, grade them in severity from one to four, depending upon how far they extend down the duodenum. Radiographically, Schmitt[15] has described three typical features: (1) A central area of translucency accompanied by transitory, moderate foreshortening of the antrum, and slight shift of the pylorus to the left. This translucency is caused by the intussusceptum which prevents the accumulation of barium. (2) Converging axial striations in the stomach and/or the duodenum. (3) Parallel transverse striations running perpendicular to the axial striations, but parallel to each other.

PATHOGENESIS

Several interesting thoughts have been advanced as to the causative factors for these localized growths. Some observers, e.g. Helwig[10] believe these growths result from local injury response in the mucosa similar to granuloma pyogenicum. This, of course, shows localized overgrowth of granulation tissue and an exaggerated endothelial proliferation. Sherman and Moran, [16, 17] carried this theory into the laboratory and produced histologically similar lesions in the stomachs of rabbits, by submucosal injection of gastric juice and ground-up food mixtures. Whether this can occur as a result of localized gastritis or ulceration is problematical.

After a polyp has started, however, it is obvious that it can be enlarged by mechanical action and traction of the food content of the stomach and the peristaltic waves.

Superficial ulceration, which has been reported frequently, may be due to interference with the blood supply, or mechanical or chemical factors, or a combination of factors.

It is our opinion that these lesions may develop either from a localized area of gastritis due to varying etiology: trauma, chemical irritation, localized congenital mucosal hyperplasia, or fibroepithelial polyp. Such lesions are constantly subjected to traction and are irritated. The mucosa becomes thickened and sometimes ulcerated. The muscularis mucosa undergoes hypertrophy, and the submucosa suffers edema, inflammatory cellular infiltration and marked fibrous tissue proliferation so that the greater share of the polyp consists of an inflammatory fibrous tissue core. If there is associated hypermotility or chronic gastritis, the traction is of greater force and this inflammatory fibroid polyp becomes more redundant, develops a

larger stalk, and drags the surrounding mucosa with it. Ultimately, prolapse or intussusception results.

SYMPTOMS AND LABORATORY FINDINGS

Symptomatology depends somewhat upon the size of the lesion. The most common complaint is epigastric pain, which occassionally is accompanied by vomiting. Hematemesis and/or melena are frequent. When the growth is large enough to prolapse into the duodenum, intermittent pyloric obstruction may occur. The symptoms of obstruction may be relieved by lying down. A higher than normal incidence of achlorhydria has been noted as it has with adenomatous polyps and carcinoma. Pernicious anemia has been found in several patients. Weakness from anemia may be a prominent symptom. These symptoms may be present over a considerable number of years. A history of allergy and eosinophilia have been present in only an occasional patient with the localized type, whereas, they have occurred in a high percentage of patients with the diffuse types.

Roentgenographically, the lesion appears as a benign tumor, sometimes with superficial ulceration and located primarily in the antrum.

Therapy is primarily surgical because of the possibilities of confusion with a malignancy and in order to eradicate the symptoms. The preferred treatment, if the nature of the lesion can be substantiated by frozen section, is localized resection. In other cases, in which large sections of the stomach are involved, segmental or partial gastrectomy may be preferable.

SUMMARY

Reports of inflammatory granulomas of the stomach are increasing in frequency. The etiology of these lesions is unknown; they probably result from local gastric injury. They cause epigastric distress, achlorhydria and may prolapse and obstruct the duodenum. Allergy and eosinophilia are usually not present. The term eosinophilic granuloma is a misnomer and should be replaced by inflammatory fibroid polyp.

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Pancreatic Pseudocysts, Follow-up Results of Internal Drainage

By J. D. HURLEY, M.D., L. W. WORMAN, M.D., and C. L. HOPPER, M.D.

Milwaukee, Wisconsin

PSEUDOCYSTS* of the pancreas continue to provoke considerable controversy when treatment is discussed. Brandenberg, Maddock and Schweitzer first advocated internal drainage in this country 10 years ago,[1] although the technique was popular in Europe prior to this time.[2] Internal drainage is easily accomplished by connecting the lumen of the cyst with that of the stomach or small intestine.

In 1956, Warren and Cattell felt that there were few indications for internal drainage and cited massive gastrointestinal hemorrhage as a complication of the procedure. They advocated simple exploration, aspiration and catheter drainage via a stab wound. This technique, they felt, obviated one of the greatest objections to marsupialization, namely the skin irritation.[3] Our experience is that external drainage, whatever the method, prolongs morbidity and that it is associated with a high recurrence rate. On the other hand, untoward complications, prolonged convalescence, and recurrent cysts were not encountered in our small series of patients having internal drainage.

*Pseudocysts of the pancreas are not true neoplasms but are collections of pancreatic secretions in the lesser peritoneal sac. They have no epithelial lining; their walls are formed by the peritoneum of the lesser sac.—CHADOFF, RICHARD J.: Pancreatic pseudocysts, *Ann. Surg.* 128:981 (Nov.) 1948.

Presented before the Wisconsin Surgical Society at the 120th annual meeting of the State Medical Society of Wisconsin, May 4, 1961, Milwaukee.

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MATERIALS AND METHODS

The first cystogastrostomy was done at the Milwaukee County Hospital in 1956. We have attempted to review the charts of all patients with pancreatic pseudocysts operated upon since that time.

Thirteen patients had surgery for pancreatic pseudocysts in the five-year period from 1956–1960 (Table 1). There were four males (two of them Negro) and nine females (two of them Negro). Two patients were over 70, the other 11 ranged in age from 27 to 51 with the mean age being 38.

There was a history of alcoholism in 11 of the 13, with 2 of the 11 claiming to be only moderate drinkers. One patient had stones in the gallbladder and common duct. Two of the alcoholic patients had associated biliary tract disease. One patient had a normal gallbladder at surgery but had a stenosis of the sphincter of Oddi at autopsy.

Gastrointestinal hemorrhage was a problem in one patient preoperatively and in another postoperatively, both of whom had external drainage.

Diabetes was associated with the pancreatitis in 3 of the 13 patients, an incidence of 23 per cent, somewhat higher than the usually reported 10 to 15 per cent. The diabetes was unrecognized until acidosis supervened in one patient. Diet alone was adequate for control in the other two.

Pancreatic pseudocyst was diagnosed in the course of an acute first illness in only 3 patients. Of the 10 chronically ill patients, 5 showed sufficient systemic toxicity to be classified as acute recurrent pancreatitis and 5 were designated as chronic pancreatitis when the diagnosis of pseudocyst was established.

Amylase levels were elevated at some time in 10 of the 13 patients. The serum amylase

TABLE 1

Patient	Age	Sex	Race	Biliary Tract Disease	Alcoholism	Stage of Pancreatitis	Procedure	Cyst Amylase	Result
1	76	F	W	Yes	No	Recurrent Acute	Cholecystectomy C. D. exploration External drainage	1,400	Died 25th P. O. day No Autopsy
2	36	F	W	No	Yes	Recurrent Acute	External drainage	1,500	Persistent pain Recurrent cyst
3	39	M	W	No	Yes	Acute	External drainage	4,900	Persistent pain Recurrent Pancreatitis Questionable recurrent cyst Died 7 mos. G. I. bleeding
4	37	F	W	No	Yes	Acute	External drainage	2,350	No recurrence
5	38	F	W	Yes	Yes	Chronic	External drainage Catheter	9,600	Persistent abdominal pain Recurrent pancreatitis
6	27	F	N	No	Yes	Acute	External Drainage	12,600	Drain 6 mos. Wound infection Recurrent pancreatitis Recurrent cyst
7	78	F	W	Yes	No	Chronic	Marsupialization	Not done	Died 9th P. O. day Bronchopneumonia at autopsy
8	48	M	N	Yes	Yes	Recurrent Acute	Cholecystectomy Cystogastrostomy	13,500	No recurrence
9	51	M	W	No	Yes	Recurrent Acute	Cystogastrostomy	2,400	No recurrence 1 Yr.
10	36	F	W	No	Yes	Chronic	Cystoduodenostomy	12,800	No recurrence Died 1 Yr. Aspiration pneumonia No Autopsy
11	42	M	N	No	Yes	Chronic	Cystogastrostomy	2,500	No recurrence 6 Yrs.
12	45	F	N	No	Yes	Chronic	Cystogastrostomy	Not done	No recurrence 5 Yrs.
13	40	F	W	No	Yes	Recurrent Acute	Transgastric Cystogastrostomy	2,125	No recurrence 2 Yrs.

was never extremely high and was frequently not persistently high.

An elevated serum amylase in a patient with recurrent upper abdominal pain indicates some type of pancreatitis until proved otherwise, in our experience.

A palpable mass was present in 7 patients. An x-ray diagnosis of upper abdominal mass was made preoperatively in all patients. It is important to note, however, that 10 of these patients had frequent hospitalizations for acute and chronic recurring abdominal pain. Most of them had negative barium studies at one time; and it was not until a specific request was made of the radiologist, that a diagnosis of a mass displacing a barium-filled segment of the gastrointestinal tract was made.

The following case history illustrates the above problems in diagnosis:

A 40-year-old white woman was first seen at this hospital in 1956 with abdominal pain and swelling. She was suspected of chronic alcoholism. Ascites was present. Paracentesis demonstrated a bloody fluid. The diagnosis of portal hypertension was abandoned, because the spleen was not enlarged and the liver function tests were normal. She had had previous pelvic surgery for abnormal uterine bleeding and, in the absence of a hospital report, a provisional diagnosis of carcinoma of the ovary was entertained and celiotomy advised. The patient elected to have this done elsewhere, delaying her surgery until recurring abdominal pain caused her to seek attention. She returned here two years later, saying that only adhesions had been found. She again had abdominal pain and was operated with a diagnosis of small bowel obstruction. No mechanical obstruction was found; a mass in the left upper quadrant was thought to be kidney. She returned one month later because of abdominal pain. A mass was palpable. The serum amylase was 337. Barium x-ray demonstrated displacement of the stomach (Fig. 1). After suitable preparation, internal drainage, a cystogastrostomy was done. Her recovery was quite rewarding. She has no evidence of recurrent disease after one year, but she is drinking again and may well get into further trouble. In retrospect, examination of the bloody ascites for amylase levels would have saved her two operations and probably considerable misery and expense.

Fluid obtained by thoracentesis, abdominocentesis and culdocentesis when checked for amylase activity, will yield high levels in the

Fig. 1—Barium meal examinatian of stomach shawing displacement ta left by pancreatic pseudocyst.

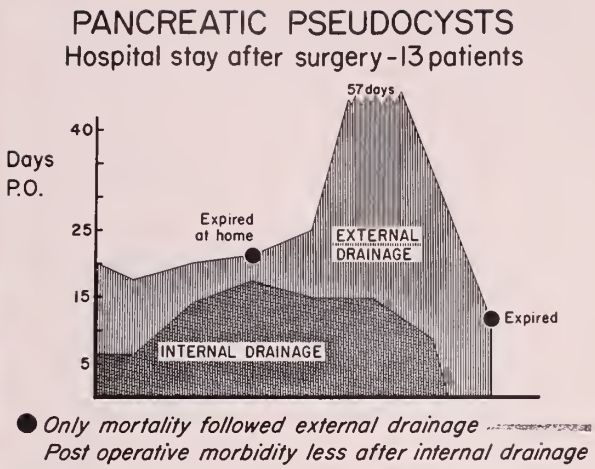

Fig. 2—Postoperative caurse of patients follawing internal and external drainage.

presence of pancreatitis; and these procedures have been helpful in making the diagnosis, in our experience.

A preoperative diagnosis of pancreatic cyst was finally made in 10 patients. Pancreatic abscess, pancreatic mass, and gastric ulcer were the diagnoses entertained preoperatively in the other 3 patients.

The cysts varied in size from 8 to 25 cm. The majority were located in the lesser sac and adjacent to the posterior wall of the stomach. One patient had two cysts, one in the head and the other in the tail of the pancreas. The cysts were multiple in one patient, presenting at several sites in the upper abdomen with at least two different types of fluid being present. The cyst had ruptured in one patient but she survived this usually lethal complication. The suitability or lack of suitability of the cyst wall for suture anastomosis was not mentioned by the surgeon in the operative note of any patient having external drainage.

The contents of the cysts were cultured at the time of operation in 10 of the 13 patients. The culture was negative in 7 and showed isolated colonies of Staphyloccocus albus in 3, which are probably to be considered contaminants.

Excision of the cyst was not deemed feasible in any case. In this series, six patients had internal drainage, five of them by cystogastrostomy and one by cystoduodenostomy. One of these patients had a concomitant cholecystectomy. The method of transgastric cystogastrostomy was used in two patients and proved a very satisfying and simple technique.

In seven patients, external drainage was accomplished by a variety of methods including multiple penrose drains, catheters and sump drains. Two of these patients had concomitant biliary tract surgery.

The postoperative course of the six patients having internal drainage was gratifying in every way. These patients were free of pain and remained so. Wounds healed well and appetite returned with resumption of gastrointestinal function (Fig. 2). All patients were ready for discharge in one to two weeks. The one patient who remained longer, was kept to control a brittle diabetes. All patients having internal drainage were followed for one to six years and remained free of pain with no recurrences of pancreatitis or pseudocysts.

The patients having external drainage did not fare so well. Two of the seven died; one, nine days postoperatively of bronchopneumonia and another, (on the 25th postoperative day) four days after discharge, of myocardial infarction. Both were elderly. The hospital course was uniformly longer following external drainage. Wound infection was a serious problem in one patient with difficulty lasting six months and a large inci-

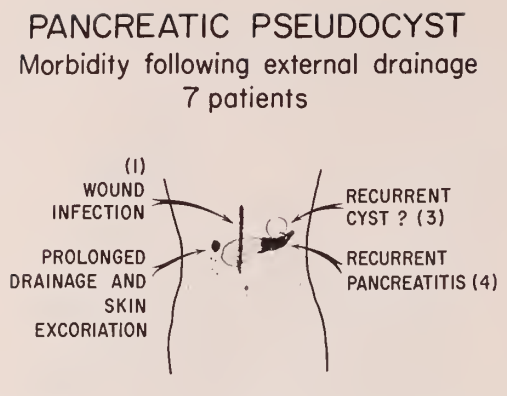

Fig. 3—Morbidity and complications following external drainage.

sional hernia resulting. Skin excoriation of some degree was present in all, but it was not considered a serious problem by the attending physician. Drainage necessitating daily dressing changes persisted for three weeks to six months, or until death in all of these patients (Fig. 3).

Severe incapacitating abdominal pain was a problem in six of the seven patients and recurrent pancreatitis necessitating hospitalization occurred in four patients. A mass was palpable in three of the four patients suggesting recurrence of the cyst and one of these patients finally had internal drainage with the result mentioned above.

DISCUSSION

That the many theoretical objections offered against internal drainage have no basis in reality, was pointed out by Sinclair in 1955.[5] Our experience would reaffirm this point. The lack of morbidity and mortality in the group having internal drainage may well reflect careful patient selection, but they also attest a wise choice of operation, for these patients did well. The efficacy of internal drainage in preventing recurrence of pancreatitis and cyst formation cannot be determined in this small series; but certainly, a comparison of the two groups suggests the superiority of internal drainage. This aspect of internal drainage is not generally appreciated, but was mentioned by Osborne and Pernokas in discussing their series of 10 patients, some of whom had been followed as long as 12 years.[4]

Early spontaneous closure of the fistula in external drainage, usually considered desirable, may have been a factor in the high recurrence rate.

The "lesser operation" of external drainage did not prolong life. The two instances of gastrointestinal hemorrhage in the series occurred in the external drainage group. Pancreatic abscess is a rare entity and cannot be diagnosed from appearance alone. It would not seem a contraindication to internal drainage if the wall were adequate for anastomosis.

SUMMARY

Pseudocysts may become evident in any stage of pancreatitis. Diagnosis of pseudocyst should always be suspected when pancreatitis is encountered (elevated amylase). Gastrointestinal x-ray studies are mandatory. Internal drainage is the treatment of choice.

8700 West Wisconsin Avenue (13).

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HIGH COST OF MEDICAL CARE

The 700 per cent rise in hospital costs during the past 25 years is largely due to increase personnel costs and not to high doctor's fees, according to George Radcliffe, Director of Office of Development at Columbus Hospital in Newark, New Jersey.

The Physician in the School Health Program

By O. R. CADE

Madison, Wisconsin

WHEN WE SPEAK of school health we are in reality voicing our concern about the health and well-being of children of school age. Inherent in this concern is an understanding of the relationship between the total health of the individual and his participation in the school experience. From this viewpoint school health begins with the infant years and continues until children become adolescents and finally adults. Thus every physician who deals with children of any age makes a contribution to the school health program.

If infants and preschool children receive adequate medical supervision and management, including immunizations at appropriate intervals and correction of correctable defects, they are much more likely to enter school as physically healthy individuals. In this event there is little need for school authorities or local health departments to make special arrangements to disclose health defects or lack of disease preventive immunizations. As was pointed out at the Eighth National Conference of Physicians and Schools, "There are a number of advantages to conducting the examinations in the office of the pupil's personal physician. Examination in the school can rarely be complete; and when therapy is needed, the examination must be repeated by the child's personal physician. Important educationally is the fact that the child and his family are obtaining preventive services in the same way as in postschool years."[1]

However, in communities where parents have not been aware of the need for preschool medical supervision, children may enter school with a wide variety of unknown and unmet medical needs. Steps then have to be taken to protect and promote the health of these children and their classmates. Since many children in Wisconsin have not had the benefit of adequate preschool medical supervision, most schools recommend a physical examination by the family physician upon entering kindergarten as well as the completion of any needed immunizations. The physician transmits a brief report to the school noting any unusual health problems which may affect the child's participation in the full range of school activities. It is important to emphasize that such a report deals with the physician's recommendations rather than the details of the examination itself. This forms the beginning of the child's school health record.

From time to time during the school years, children will be screened for such things as visual or hearing defects. An important function of the physician in these programs is that of followup with the child to make a diagnosis and institute any indicated corrections. In many instances the physician may need to interpret to parents the purpose of such screening programs, to point out that these screening programs are an activity conducted by the school to find children who are in need of medical appraisal, and that such screening programs are not diagnostic in nature. While most schools try to communicate this information to parents, many parents may not understand the need for medical followup and may become unduly concerned about such referral.

Schools need the advice of the physician in order to insure that individual children may gain the most from their school experience. Such advice is especially important when a child is under medical supervision for conditions which may require special adaptation of the school program. For example school personnel need to be informed about such problems as heart conditions, diabetes, epilepsy, orthopedic conditions, and hearing and vision defects. Such conditions may require modification in school activities for individual children in terms of seating arrangements, physical education, athletic activities, rest periods, and extracurricular activities.

Mr. Cade is Director, Division of School Health, Wisconsin State Board of Health.

It is well to point out, however, that physician-school communication should be a two-way proposition. Aside from formally organized screening procedures, teachers have a daily opportunity to observe children. Such observations may well indicate the need for medical referral and followup. Behavioral problems, fatigue, listlessness, irritability, and unusual skin conditions are but a few examples of things which may serve as the basis for medical referral. Such observations transmitted to the physician through the parent or nurse may be of significance in terms of diagnosis and management.

As children grow older there is increasing opportunity for the physician to provide health education and interpretation on a direct basis. The physician-child relationship can be of considerable significance in terms of developing the child's attitude toward health care and health promotion.

As a profession, physicians may make many other important contributions to the school health program. Physicians may become involved in working with schools in planning such health services as screening programs, physical examinations, referral procedures, developing emergency procedures, and developing school health policies.

The ultimate goal of a school health program is to make the fullest and most efficient use of community health resources to keep children as healthy as possible and to help them get the most out of their growing years. Physicians as individuals and as a profession have a key role in this endeavor.

REFERENCE

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Treatment of Diabetes

Because of its prevalence and chronicity, diabetes mellitus should be the continuing concern of all physicians, regardless of their type of practice. An essential part of treating the condition is teaching the patient how to live with it.

As in any educational program, a systematic approach should be used. Each physician should have certain specific objectives clearly in mind as he teaches his diabetic patients.

To aid him, the American Diabetes Association has prepared the following check list of nine basic elements of treatment, which constitutes a minimum program for diabetes management. There are many other aspects of treatment which are not mentioned, but they are not as important as are the following:

1. Diet
2. Urine testing
3. Action of insulin and other hypoglycemic agents
4. Technique of insulin injection and sites for it
5. Care of syringe and of insulin
6. Symptoms of hypoglycemia
7. Symptoms of uncontrolled diabetes
8. Care of the feet
9. What to do in case of acute complications

This guide is not only of value in the initial education of a new diabetic, but can also be most helpful to both patient and physician in the subsequent years of management.

Extra copies of this report are available from the American Diabetes Association upon request for distribution to individual physicians and for posting on bulletin boards.

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TRIBUTE TO A RETIRING EDITOR

By H. G. HARDMAN, M.D.
Milwaukee, Wisconsin

WE NEED HIS example more than he needs our good wishes for the coming years. This is my personal feeling for Harry Beckman who has contributed so much to the development of Wisconsin physicians and the sciences of medicine and pharmacology. Over three thousand physicians have been exposed to the colorful personality and erudite teaching of Harry Beckman in the lecture halls of Marquette University School of Medicine. First and foremost he has been a teacher par excellence. Constantly varying the technique of presenting information about the rational use of drugs to medical students in the classroom he has also taught physicians throughout the world with his extensive writings in the form of papers, textbooks, Year Books of Drug Therapy and our own state medical journal. His refreshing and crisp personal style of writing can only be compared with the outstanding medical teachers of the century.

Harry Beckman was born in Louisville, Kentucky. His early exposure to formal academic training was not to his liking and he left the classroom to explore the open spaces as a county agricultural agent. It was this early experience as teacher, naturalist and traveler that subsequently led him into the field of medical education. In his peripatetic functions as a county agent he developed a true love for books and scholarship which is undiminished in intensity after more than fifty years of daily practice. This led to his very first scientific publication entitled, "What can we do with our manure?" This paper has caused him to receive much good natured ribbing but characteristically he replies that "a man must start somewhere and pull on his own boot straps." From this beginning has evolved a professional career of scientific writing and editing unequaled by any living pharmacologist.

About 1917 he entered a formal program in medicine at the University of Louisville and received his M.D. degree in 1921. This was followed by a two year internship at the New York Skin and Cancer Hospital. A brief

career as a ship's doctor followed and then he began his long association with Marquette University as an instructor in physiology and pharmacology in 1923. He rose rapidly through the ranks and was appointed professor and chairman of the department of pharmacology in 1926. On January 1, 1962 he retired from the administrative duties of departmental chairman to devote his full efforts to research in the field of malaria and to continue editing his Year Book of Drug Therapy. As a professor of pharmacology he will continue his association with Marquette University where his colleagues will draw upon his vast experience and knowledge for help in their problems.

His perception of the important areas for improvement in the field of pharmacology and his personal effort to solve these problems led to the introduction of Training Grants from the Public Health Service for departments of pharmacology in the United States. Without this important legislation we could not hope to provide adequate numbers of teachers in pharmacology for the task of training increasing numbers of physicians for our rapidly expanding population.

There are too many examples of his wise leadership to enumerate here which reflect his character, integrity and personal generosity that his associates value so dearly. We need his example of dedication to one's work to appreciate his personal philosophy that the joy of doing a job well is reward in itself. We at Marquette University feel especially honored to have Harry Beckman as our continuing associate.

NATIONAL BLOOD SERUM CHOLESTEROL SURVEY TO BE CONDUCTED BY THE COLLEGE OF AMERICAN PATHOLOGISTS

The measurement of serum cholesterol as presently practiced is admittedly unsatisfactory because of wide variations in results. This variability is attributable to the use of diverse methods, and to the unavailability of an acceptable universal standard.

The estimation of serum cholesterol, long used in the study of diabetes, nephritis and disorders of the liver, has become of added importance in recent years because of the relation of cholesterol metabolism to atherosclerosis and heart disease. The need for a procedure which will give reproducible results from place to place and from year to year is imperative.

It is the purpose of the Standards Committee of the College of American Pathologists to characterize a best cholesterol standard for universal use, and to recommend an analytical procedure which may serve as a consistent point of reference.

This national preliminary survey of serum cholesterol estimations is being organized to disclose the present status of this chemical procedure. All laboratory directors and pathologists in the United States will be invited to participate.

Inquiries may be addressed to Cholesterol Survey, College of American Pathologists, Prudential Plaza, Chicago 1, Illinois.

RARE SERUM AVAILABLE FOR INFLUENZAL MENINGITIS

Production of a year's supply of a rare serum, for use in sudden and severe attacks of influenzal meningitis, was made known by the pharmaceutical firm of E. R. Squibb & Sons, Division of Olin Mathieson Chemical Corporation. The serum, called Anti-Hemophilus Influenzae Type B, is the only known cure in those few cases which do not respond to conventional antibiotic treatment.

The company discontinued making the serum five years ago when it appeared that influenzal meningitis could be cured by antibiotics. However, in a small number of cases antibiotics apparently do not work. In these instances, Squibb has been called upon by physicians for a supply of its serum. In many cases the drug has had to be dispatched on a lifesaving emergency basis. The serum is now available on a 24-hour basis from Squibb branch units in San Francisco, Chicago and New York.

Although the cost of producing a little over a thousand vials of the product, the estimated demand for a twelve-month period, is nearly double what the firm will sell it for, past experience showed that it was essential that this serum be made available when needed.

PRESIDENT'S PAGE

"Action—Keeps Honor Bright"

THE LONG ROAD to professional excellence in medicine is not an easy one. Once the goal is attained, it is equally difficult to maintain that pinnacle of high purpose and dedication. Just as our spiritual side gains strength and greater aspiration by being concerned with matters of the spirit, so that part of our lives concerned with medical practice requires constant renewal and refreshment.

It has never been easy to practice medicine. The early Greek, more than 2,000 years ago, who pondered on this difficulty with time, the art, knowledge and judgment, reminds us of this. The problems and burdens of carrying on day-by-day service to one's patients have not been eased during the interim. What with growing intervention by well meaning but misinformed groups, the flexing of union organization muscles that would have one believe that human ailments and anxieties can be allayed by the same assembly line methods used in building cars or in mining coal; management and industry that find themselves caught between the anvil of socialization pressure and the hammer of political artisans creating untapped voting blocs, and the ceaseless fanatical gyrations of the welfare state advocates . . . it is a wonder that the medical profession has survived at all! The fact that it has survived would indicate that it is made up of tougher fiber than our critics realize. For this we may thank those who preceded us and gave us the momentum to propel us into space and to continue to orbit.

But this momentum is losing its speed and will continue to slow down unless we accept our proper responsibilities. The practice of medicine is a jealous mistress. Beyond our personal interests and life of ministering to the sick, your county, state and national organizations desperately need your active support. Ours is a great democratic body with an organizational structure which has been imitated by many other groups. Directives do not come from on high as in the councils of labor and management. The executive and staff authority stems directly from your elected delegates.

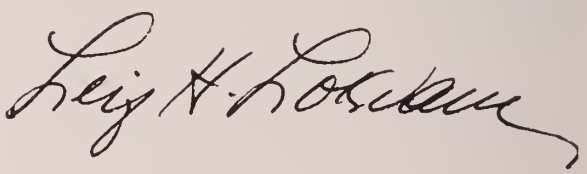
The demands upon the individual of such an organization are great, much greater than in an autocratic structure. Therefore, it is not enough to have discussions and make critical evaluations that never go beyond the cloakroom, corridor or operating area dressing room. The fierce demands to maintain an unfettered freedom within the bounds of reason, freedom from dictation within and without organized medicine, compel us to action, to participate and to create so that we may achieve the ultimate in the care of the sick.

If we are to expand our lives personally and professionally and thereby render greater service to society and especially to those who look to us for relief of pain and release from suffering, we must be active. All life is action and in this man has found his greatest joy and reward. But our powers of perceptive response must be unfettered if we are to join in this action. To fail in this response is to separate us from our colleagues and isolate ourselves from the medical community.

One direction of this action fast approaching is the annual meeting of your State Medical Society in May. Your officers, staff and especially the Scientific Commission have given of their time and talents in this labor over the past year. Let us join with them and our fellows in the mainstream of medical progress and in so doing find that inspiration so necessary for the constant renewal of our medical spirit. Let us not wither from scientific self righteousness and shrivel from personal isolation of our medical lives. The physician who does not avail himself of participation in the scientific and organiza-

tional meetings and receive and give freely of ideas, is no better off than if all this had been denied him.

Most of the world's great religious faiths recognize divinity in the world about us, in the flower that blooms, the tree that grows, the bird that flies, in mankind that reasons and knows compassion. Should we not equally recognize scientific truth and excellence in our medical world about us by our active participation and our faithful efforts in its behalf? In this faith we may help keep the bright light of medical freedom burning. In this devoted action we may continue to maintain the freedoms that are cherished by all, and preserve them for those who come after us.



LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison 1, Wisconsin.

1. **Interprofessional Code**
   An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.

2. **Guide to The Service Corporation Law**
   A series of questions and answers describing Chapter 350, Laws of Wisconsin, 1961, allowing physicians, among others, to form private medical corporations for the tax benefit of their stockholders.

3. **Code of Necropsy Procedure**
   A guide to physicians, hospitals, and funeral directors in the performance of necropsies.

4. **Hearing Conservation Programs for Wisconsin Industries**
   Some recommended standards and principles for providing a hearing conservation program in industry.

5. **Occupational Health, A Guide for Medical and Nursing Personnel**
   General principles and suggested plans for an industrial health program, with emphasis on written procedure for nurses.

6. **Medical Care of Migrant Agricultural Workers**
   A guide to physicians and operators of licensed industrial camps in Wisconsin on the formulation of a local plan for the care of migrant workers.

7. **Guide to Immunization Planning**
   An approved guide including recommended procedures for routine immunizations, parental responsibility, physician responsibility, medical society responsibility and steps for successful community planning.

8. **A Guide for Physicians, Hospitals and News Media**
   A discussion of news relationships between physicians, hospitals, newspapers and radio and television stations. It includes information concerning patients, physicians and county medical society news, health educational efforts and advice on the use of the title "Doctor."

9. **Inspection of Medical Records**
   An interpretation of Chapter 301, Laws of 1959 relating to the right of access to physician and hospital records concerning patient care. Sample consent forms are included.

10. **School Health Examinations**
    A guide for physicians and school authorities in establishing a program of school health examinations.

11. **School Vision Screening Program**
    An outline to facilitate the development of a program to detect significant visual defects among school children.

12. **Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers**
    A list of the objectives of the State Medical Society in devising the Wisconsin Plan and the conditions under which insurance carriers may participate in that plan.

13. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**
    Relating to fee splitting between physicians and others.

14. **The Doctor's Role in Adoptions**
    A reprint of three Wisconsin Medical Journal articles issued by the Division for Children and Youth, State Department of Public Welfare, Madison.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Postal Blight

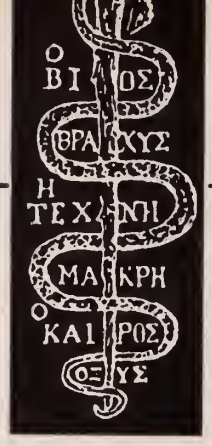
MAIL-ORDER PRESCRIPTIONS, the latest nightmare to disturb the retail drug industry, could develop into an annoying public health problem as well as a serious threat to the local druggist's income. While it is hardly likely that a patient will mail-order to Chicago, Los Angeles or Union City, Tennessee, for a prescription he needs immediately, it is very probable that the attraction of a money-saving price will induce him to mail-order pharmaceuticals that he uses constantly over a long period of time. When this happens the patient-physician-pharmacist relationship is disturbed, and the element of control necessary to successful medical care is compromised.

When a patient has a prescription filled locally, the pharmacist who fills it is subject to the same pressures enjoining conscientious performance as any other professional man in the same community. But when the prescription is filled hundreds of miles away, the patient is merely an unseen customer who may or may not order again, and the prescription is reduced to the status of a commodity to be produced in greatest quantity at lowest cost.

To combat the evil that mail-order prescriptions could become, the cooperation of both physicians and local druggists is required. Doctors should urge their patients to think twice before succumbing to the temptations of mail-order economy in the area of ethical pharmaceuticals. The delays inherent in mail-ordering as well as the uncertainty as to what is delivered—and when—should convince the reasonable patient that he is ahead by having his prescription filled by his regular local druggist.

At the same time the local druggist can make mail-order prescriptions less attractive by reviewing his pricing policies. The patient's ignorance of what a pharmaceutical should cost and the emergency nature of the prescription must never encourage an unconscionable over-charge. Apart from price, the local druggist can look to the improvement of the quality of his service as well as to the enhancement of the concept of the pharmacist as a professional person rather than as a competitive businessman.

Patients can't be blamed for wanting to save a dollar or two where possible. It is up to the doctor to explain the danger of mail-order pharmaceuticals, and it is up to the druggist to make it as unattractive as possible to write away for drugs. If doctors and pharmacists help each other in this respect, the growth of mail-order prescriptions can be restrained and the public health problem it poses can be avoided.—D. N. G.



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THE MEDICAL FORUM

Council Approves Teaching Of Two Programs Of Emergency Care To Non-Medical Persons

The Council of the State Medical Society, on February 24, approved two programs of emergency medical care to be taught to non-medical persons in the state.

One, related to civil defense, involves the eventual training of over one million persons in Wisconsin to provide medical self-help to their families in case of nuclear attack.

The second is a newly developed life-saving technique called external cardiac massage.

EXTERNAL CARDIAC MASSAGE

The heart massage technique will be taught to emergency personnel such as police and fire rescue squads by individual physicians through the state and county medical societies.

A special program will be presented at the annual meeting in May on the subject, and the State Medical Society is urging every hospital staff in the state and each county medical society to have a physician representative attend the program. These physicians will then present programs on request in their own communities.

The State Medical Society will furnish a special manikin and film to be used in the instruction programs.

MEDICAL SELF-HELP

The civil defense medical self-help plan, developed by the Public Health Service in cooperation with the American Medical Association, is now underway in the state as a pilot program in 80 preselected sites.

The state and county medical societies will promote the program and urge physicians to contribute

(Continued on page 194)

SELF-HELP MEDICAL CARE, a civil defense program, was approved for teaching to Wisconsin residents by the Council at its February meeting. Left to right, Drs. R. W. Mason, Marshfield, V. E. Ekblad, Superior, and E. D. Sorenson, Elkhorn, examine some of the teaching materials. Doctor Mason is councilor from the Ninth District, Doctor Ekblad from the Eleventh District, and Doctor Sorenson is past president of the State Medical Society.

Dr. James C. Fox Reelected Chairman Of Council Of SMS

Dr. James C. Fox, La Crosse, was reelected chairman of the Council of the State Medical Society at the annual meeting of the Council on February 25.

Doctor Fox was first elected to the Council in 1947. This is his fourth term as chairman.

Also reelected were Dr. John M. Bell, Marinette, vice-chairman; Dr. F. L. Weston, Madison, treasurer; and Dr. H. Kent Tenney, Dr. John T. Sprague, and Dr. E. J. Nordby, all of Madison, assistant treasurers; and C. H. Crownhart, Madison, secretary.

Dr. V. S. Falk, Jr., Edgerton, was elected medical editor of the *Wisconsin Medical Journal.* He succeeds Dr. R. S. Baldwin, Marshfield, who retired after 12 years in the position. Doctor Baldwin was named consulting editor. Dr. D. N. Goldstein, Kenosha, was reelected editorial director of the *Journal.*

Council Approves Teaching of Emergency Care

(Continued from page 193)

their time to supervise the medical care teaching aspects.

Each course, for 25 persons, will cover 12 subjects ranging from sanitation to emergency childbirth. The program is designed to enable people to meet their own medical needs during a post-attack period when normal medical care might not be available due to physicians being involved with care of casualties or unable to travel due to fallout.

The program will be taught in Wisconsin through the Department of Public Instruction, State Board of Vocational and Adult Education, county civil defense units, and University of Wisconsin Cooperative Extension Service.

One of the first courses in the Madison area is being conducted for employees of the State Medical Society and members of their families. Dr. David *Williams*, Madison, a member of the Committee on Disaster Medical Care of the Society, is the instructor.

EXTERNAL CARDIAC MASSAGE, an emergency procedure which the Council of the State Medical Society reviewed at its February 24–25 meeting, is demonstrated above by Dr. E. J. Nordby, Madison, for Dr. P. B. Blanchard, Cedarburg, center, and Dr. J. H. Houghton, Wisconsin Dells, right. Doctors Nordby and Houghton are councilors for the Third District and Doctor Blanchard represents the Fifth District. The manikin shown and a film are available for teaching the program to hospital staffs and emergency personnel in the state.

Cancer Groups Meet To Discuss Action On Detection Program

The Committee on Cancer of the State Medical Society and the Cancer Coordinating Committee, made up of members of various organizations in the state, met February 17 at the State Medical Society headquarters in Madison.

Among the reports and actions were:

1. A review of the policies and programs of the State Laboratory of Hygiene as they apply to the field of cancer diagnosis.
2. Suggested approaches to teaching colon and rectal cancer detection and examination.
3. Expansion of membership of the Coordinating Committee to include other groups.
4. A program of postgraduate education in cancer detection and treatment through short articles in the *Wisconsin Medical Journal.*
5. Appointment of Dr. Robert Samp, Madison, to represent the two committees at the Cancer Registries Conference in Detroit, Michigan, held March 7.

TETANUS CLINICS HELD

The Lafayette County Medical Society, in cooperation with the Lafayette County Health Committee, conducted in February a series of tetanus immunization clinics for adults.

Initial injections were given at clinics in six communities with the second to be received from the family physician of the individual.

STRONGLY RECOMMEND DENTAL GUARDS FOR 1962 FOOTBALL GAMES

The Wisconsin Interscholastic Athletic Association February 22 decided to strongly recommend the use of dental guards during the 1962 high school football season.

The WIAA's board of control said it decided against making the guards mandatory because of difficulty in enforcing such a rule and because it felt more education about the guards is needed.

In making the announcement, the board stated it believes "benefits in wearing dental protection are unquestionable." The WIAA said dental injuries were cut by 20 per cent in Wisconsin in 1961 when they conducted an experimental program in which about 10,000 guards were worn.

State Medical Society Starts Regional Service

A regional service of the State Medical Society, with staff representatives stationed in four centrally located areas, was approved at the meeting of the Council February 24–25.

It is felt that the establishment of the regional service would enable the Society to serve members over the state in a more effective manner.

The plan, developed by the Planning Committee of the Council, calls for establishment this year of three regional service areas—in Eau Claire, central Wisconsin and the Fox River Valley. A fourth area covering the southern portion of the state will be served out of the home office during 1962.

Each area will be staffed by one full time regional representative. Two way communication between state and county societies—by personal visit, working with county medical societies and organized hospital medical staffs, conference with employees of physicians—will be the major emphasis.

Some specific activities will be further implementation of the Society's placement service, visiting new physicians, assisting in grievance cases in the locality, coordinating education in fields of national and state legislation, making local news media contacts and helping with medical military service problems.

The first regional representative under the program is Robert W. Dawson. He began employment with the Society on March 1, and has been at the home office in Madison for an intensive training program.

Dawson, widely known in west central Wisconsin, was formerly news director of WEAU–TV, Eau Claire, and was previously associated with Rib Mountain TV and Radio Station KCBC, Des Moines, Iowa.

He will operate out of Eau Claire, and serve physicians in the western one-fourth of the state, from La Crosse to Superior.

While the regional men can do much to assist local auxiliaries, the plan also involves having Mrs. Leona Chesemore, Madison, who is presently serving as staff for the auxiliary, extend her activities into the field on a limited basis.

Foundation Trustees View Student Loans

The Executive Committee of the Board of Trustees, Charitable, Educational and Scientific Foundation of the State Medical Society met January 21 in Madison at the Society headquarters.

The major topic under discussion by the Executive Committee was the Student Loan Fund of the Foundation which continues to need added funds to meet the requests of medical students for aid.

Actions Taken By Council Of Interest To Society Members

Numerous actions were taken by the Council of the State Medical Society February 24–25 in Madison which will be of interest to physicians in the state.

The Council is the Board of Directors of the Society.

Following are some of the actions taken:

1. Approved a pilot plan in Eau Claire to establish a public health "listening post" to encourage citizens interested in health matters to work with physicians in effective community health action. If successful it could be expanded to other areas in the state.
2. Approved appointment of a committee of Council members to review studies in the area of utilization of all forms of voluntary health insurance.
3. Forwarded to the House of Delegates a suggested bylaw amendment requiring the chairman or an appointed member of each standing committee to attend the appropriate reference committee of the House to amplify or discuss the annual report of his committee.
4. Authorized the Society's general counsel to act as amicus curiae (friend of the court) in any suit involving the personal service corporation law, or in any Internal Revenue Service interpretation or involvement in it.
5. Approved a proposal for a Wisconsin Week of Health, to be proclaimed by the Governor, which would provide an opportunity for county societies and other organizations in the health field to focus attention on the progress of medicine and health in Wisconsin.

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Service Corporations Ethical, American Bar Association Says

The Committee on Professional Ethics of the American Bar Association, in an opinion announced in December, declared that it is ethical for lawyers to form "associations" or "corporations" for federal tax purposes if the substance of the organization meets the requirements of the canons.

The opinion is significant in Wisconsin in view of the Service Corporation Law, passed by the 1961 Legislature, which allows physicians, lawyers, and others to form private corporations for the purpose of deferring taxation on retirement funds until the benefit is received.

The headnote of the opinion said:

"Lawyers who practice law in a form of organization usually designated a professional association or professional corporation, which has the characteristics, in whole or in part, of limited liability, centralized management, continuity of life, and transferability of interests, may be, but are not necessarily, acting in violation of one or more of the canons. The mere fact that the form of organization used by lawyers to practice law is a professional association or professional corporation does not in and of itself constitute a violation of any canon as it is the substance of the arrangement and not the form that is controlling."

The ABA opinion went on to say that there remains some doubt whether recent enabling state laws will in fact result in such associations or corporations being classified as corporations by the federal taxing authorities.

As to the wisdom of lawyers adopting the corporate or association form of organization for the practice of law, the ABA Committee noted that "the members of the Committee have grave doubts."

In its conclusion, the Committee stated: "The question initially presented in this opinion—Can lawyers carry on the practice of law as professional association or professional corporation . . . is answered in the affirmative provided appropriate safeguards are observed."

News Briefs

SHEBOYGAN MEDICAL ASSISTANTS COURSE

A new course for training medical assistants will begin next September at the Sheboygan School of Vocational and Adult Education.

Among committee members formulating plans for the course are Dr. Harris A. Weisse, Plymouth, and Dr. Otto Stewart, Sheboygan.

It will be a one-year course that would provide the student with the skills needed to conduct the business office activities as well as medical-technical activities of a medical assistant in a physician's office, a hospital or clinic.

The course is being arranged in cooperation with the Sheboygan County Medical Society and the Wisconsin State Medical Assistants Society.

RACINE COUNTY SOCIETY HAS NEWSLETTER

The Racine County Medical Society has established a Presidential Newsletter which will be issued on a monthly basis.

The first issue, by Dr. Frank M. Hilpert, president of the society, was published February 9.

GUEST EDITORIAL

GREEN BAY PRESS-GAZETTE

THURSDAY EVENING, FEBRUARY 8, 1962

Problems of the Aged

It was a thoughtful summary that Gov. Gaylord Nelson read to the members of the new state statutory Commission on the Aging as he greeted the group at its first meeting in the state capitol the other day. But it betrayed also, it seemed to some listeners, a temptation on the part of the political head of the state to suggest premature conclusions to the study group which owes its creation to him.

The Governor talked about the problems of retirement and employment and recreation of the elderly among us, about the possibilities of providing vocational retraining services for the benefit of those persons who have been retired from their usual work but who have a will and energy remaining for some kind of productive employment, and related topics.

But then he launched into a discussion of the health problems of the aged and virtually proposed that the group get behind the campaign to enact a federal government health care program through the instrument of the old age and survivors' insurance program.

The governor is committed to that method of meeting the health care and medical economics problem of the elderly. He has a right to his viewpoint. It is widely shared, as is evident in the heightened national discussions on the subject as Congress currently considers it. But it is scarcely a graceful gesture toward a group he created for investigation and study, as preliminaries to conclusions and recommendations.

The Governor said he is convinced, without quite explaining how he came to be convinced, that private health insurance contracts can not be adequate for most Americans. Yet the record shows that there are millions of Americans so enrolled, to their own satisfaction and to those of their families. He appears to reject the idea of a state medical care program, as contemplated under the Kerr-Mills federal act which offers a share of the money such state legislation would involve, out of hand. Indeed, he doesn't even mention it in his charge to this investigative group, although the issue was before the legislature which departed the capitol only a few weeks ago.

We will credit the Governor with the humane concern for the happiness and comfort of our elderly citizens that is shared by the vast majority of his constituents. But we wish he would concede that these are difficult and complex matters, and that there is no divinely ordained method of approaching them. We wish also that he would concede, even obliquely, that there are many other men of good will who dread the collectivist implications of his choice.

Appeal Made For Medical Books, Instruments

Medical Missionaries Need Used Textbooks

Used medical textbooks, not more than four years old, are badly needed by medical missionaries in 19 foreign countries.

The request was made recently by Mr. Raymond Knighton of the Christian Medical Society. The books would be used by his organization and also the Christian Medical Council of the National Council of Churches and the Catholic Medical Mission Board.

Physicians wishing to donate books may send them directly to: Christian Medical Society, 7212 Circle Avenue, Forest Park, Illinois, or to the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. Books donated to the missions through the Foundation are tax deductible.

Further information may be obtained by writing Mr. Raymond Knighton, 1122 Westgate, Oak Park, Illinois, or to the State Medical Society of Wisconsin.

Brazil Charity Hospital Asks Physicians' Help

A 340-bed charity hospital, operating on a yearly budget of $25,000, has made an appeal to American physicians for medical instruments desperately needed to adequately equip the hospital.

The request comes from the Santa Isabel Hospital, Bahia, Brazil, through the United States Consul there.

One of the oldest hospitals in the Western Hemisphere, Santa Isabel serves about 83,000 patients a year and has a staff of 75 physicians. There are also 200 medical students and four residents at the hospital.

Equipment at the hospital has become antiquated and inadequate, and dwindling income has made the introduction of more modern techniques painfully difficult, states Consul James M. Flanagan. Even equipment obsolete by American standards would be welcome.

Equipment needed ranges from an ambulance (the hospital is now operating without even one) to minor surgical items. Dr. Durval P. Olivieri, director, has submitted a list of over 125 items needed by the hospital.

This includes a large number of items for the out-patient department, clinical laboratory, children's clinic, ophthalmologic surgery, x-ray department, and general surgery department.

A complete list is available upon request from the State Medical Society.

Equipment can be donated through the Charitable, Educational and Scientific Foundation of the State Medical Society, or prospective donors may write directly to Durval P. Olivieri, M.D., Santa Isabel Hospital, Salvador, Bahia, Brazil.

TEXTS REQUESTED

Text of Medicine—Cecil
Current Therapy—Conn, 1961
Christopher's Surgery—Davis
Obstetrics—Greenhill
Urology—Campbell
Pharmacological Basis of Therapeutics—Goodman and Gilman
Diseases of the E N & T—Ballenger & Lederer
OB & GYN—Wilson, Beechman, Forman and Carrington
Operative Orthopedics—Campbell
Tropical Diseases—Manson
Pediatrics—Mitchell—Nelson
Diseases of Metabolism—Duncan
Principles of Practices of Anesthesiology—Collins
Hematology—Wintrobe
Pharmacology—Beckman
Surgery of Infancy and Childhood—Gross
Operations of General Surgery—Higgins & Orr
Roentgen Signs in Clinical Diagnosis—Meschan
Manual of Dermatology—Published by Saunders for the Army
Ophthalmology—Gifford
Pharmacology—Sollman
Surgical Errors and Safeguards—Thoreck
Office Gynecology—Greenhill
X-Ray (6 volumes)—Yearbook Publishers

NEWS STORIES TO TELL IF ACCIDENT VICTIMS UTILIZED SEAT BELTS

The Associated Press, a news-gathering organization serving many news media in Wisconsin, reports that wherever possible, its news stories on auto accidents will include information on whether automobiles involved in fatal accidents are equipped with seat belts, and whether the seat belts were in use.

The project has won the personal endorsement of Gov. Gaylord Nelson.

The Governor stated: "The tremendous effect seat belts can have in cutting down both the number and the severity of injuries is well documented in some of the best research done in the traffic safety field."

He said the plan of the news service "can in the long run do much to convince people that they stand to improve their chances of surviving an accident without serious injury if they use this inexpensive and convenient device."

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Two State Programs Reviewed By Division On Chest Diseases

The Division on Chest Diseases of the Commission on State Departments met February 15 in Milwaukee and discussed features of the State Board of Health hypertension screening program, rheumatic fever registries, and the Bicillin program of the Bureau for Handicapped Children of the State Department of Public Instruction.

In viewing the hypertension program, developments since 1949 were reviewed, and a program was explained under which the State Board of Health would study whether cardiac enlargements indicated on 70 mm. film might be distorted and not correspondingly large if taken on 14-by17-inch film.

The Division agreed that the proposed study should be conducted and that a grid method of measurement for both type films was practical and should be employed.

Dr. Milton Feig, of the State Board of Health, reported that he and his associates are planning a number of research studies associated with the hypertension program.

He also outlined a plan for the possible establishment of a statewide registry on those experiencing rheumatic fever. No definite action has been taken, but if such a program is undertaken, the State Medical Society will be asked to participate in its planning and promotion.

In reviewing the Bicillin program, the Division:

1. Agreed the Bicillin is an effective drug, and should be continued in the program of the Bureau for Handicapped Children.
2. Stated that the cost of Bicillin, or benzathine penicillin G, is much greater than the cost of an equally effective drug, sulfadiazine.
3. Agreed the profession should know of the alternative use of these drugs and the difference in cost to the patient and made plans to publicize the fact.

Members of the Division are: Drs. H. A. Anderson, Stevens Point, chairman; George R. Barry, Monroe; J. Richard Johnson, Madison; George E. Magnin, Marshfield; John Rankin, Madison; Raymond H. Evers, Plymouth; John H. Huston, Milwaukee; Thorolf E. Gundersen, La Crosse; Warren K. Simmons, Rhinelander; and Einar R. Daniels, Milwaukee. Representing the State Board of Health on the Division are Drs. Milton Feig and Josef Preizler, both of Madison. Dr. Richard P. Jahn, Milwaukee, medical director of the Wisconsin Anti-Tuberculosis Association is a special invitee.

Brown County Society Resolution Opposes King-Anderson Method

The Brown County Medical Society, at its February meeting, passed a resolution favoring the Kerr-Mills approach to finance medical care for persons over 65, and opposing the King-Anderson method of setting up a program under social security.

The resolution reads:

"As citizens and physicians we are deeply concerned over the proposed legislation to pay for medical care of people over 65 through an increase in the Social Security tax.

"The Kerr-Mills Bill seems to us to be a better and more practical means of handling the situation and we urge that it at least be allowed to demonstrate what it can do. In our experience, older people pay their hospital and doctor bills more promptly and more reliably than many young married couples with small children.

"We feel that medical care needs and medical care expenses are not exclusively a problem for those over 65. Those who need help should have it regardless of their age—those over 65 should not have their bills paid by taxing the younger workers.

"The social security approach will not decrease the cost—it will simply shift it to other shoulders and add the burden of countless clerical workers to do a job already being done in a manner envied by the rest of the world."

News Briefs

NEW COURSES AT UW–MILWAUKEE

The University of Wisconsin–Milwaukee has announced that it will soon offer a four-year B.S. degree program in medical technology and the first half of a four-year nursing program.

The medical technology program, already approved, will consist of three years of academic training and a fourth year of practical study in a hospital.

The nursing program will initially offer students two years of training in Milwaukee, with the practical training in hospitals in Madison.

Definite steps toward entry of the institution into training of physicians have not yet been taken, although physicians and educators have discussed the proposal.

MARINETTE TB TESTING

Tuberculosis skin testing was completed on 685 students in Marinette schools in February, according to Mrs. Marcella Buchman, city nurse.

Physicians of the Marinette County Medical Society donated their services in the administration and reading of the tests.

"All of the volunteers are to be commended for their fine performance in making these clinics possible in the efforts of communicable disease control in Marinette," Mrs. Buchman said.

Dr. Bachhuber Appointed To Health Board

Dr. Harold A. Bachhuber, Sauk City, was appointed February 22 to a seven-year term on the State Board of Health.

Doctor Bachhuber suceeds Dr. Joseph C. Griffith, Milwaukee, on the eight-member board which establishes policy and regulations for operation of the State Health Department.

A graduate of the University of Wisconsin Medical School, Doctor Bachhuber has practiced medicine in Sauk City for 30 years.

New Film On King–Anderson Bill Available

"The future of American medicine may be decided in 1962, and it's going to be decided politically," states Dr. Edward R. Annis, Miami, Florida, in a new 25-minute film available on loan to county medical societies and individual physicians for showing to the public.

The issue, of course, is the King-Anderson Bill, presently before Congress. The new film is designed to present a comprehensive picture of medicine's views on such legislation.

Here are some of the points brought out by Doctor Annis:

1. American medicine and its allied professions have developed a system of medicine which has known no peer in history. Yet there are people in this country who want to change it for a system which has been a proven failure.
2. They say it is:
   . . . an insurance program, which it is not.
   . . . an extension of social security, which it is not.
   . . . has built-in safeguards against government intervention in medicine and operation of hospitals, which it does not.
   . . . a program which doesn't include physicians, but it does.
3. In a recent survey:
   . . . Seventy per cent of men over 65 and 64 per cent of women reported their income as adequate to meet their needs.
   . . . Eighty-five per cent said that in the preceding year they had not had or did not need medical care they could not pay for.
   . . . Half of them said they could easily afford a $1,000 emergency hospital, doctor, drug or general medical bill.
4. The Federal Reserve Board reported in July of 1959 that 69 per cent of Americans over 65 have no debts whatever. The Board study revealed that of those who are in debt, only 6 per cent have debts in excess of $500.
5. Nine million Americans over 65, which is more than 53 per cent, have protected themselves with health insurance against the cost of illness, and the number is growing every day.

"Physicians are not opposed to health care for the aged as you may have heard," Doctor Annis states. "But we are opposed to saddling the working people of this nation—and their children—with the burden of another tax, a burden that would fall heaviest on those of moderate income, to pay the medical bills for several million other people who can well afford to pay for their own."

"Physicians are opposed to importing a system of medical care that doesn't work and substituting it for our system that does work."

Reservations for the film may be made by writing: State Medical Society, Box 1109, Madison 1, Wisconsin.

Vernon County Broodcoster-Censor Photo

CIRCUIT TEACHING PARTICIPANTS view a slide used in one of the presentations during the sessions which were held January 31 at Viroqua and February 1 at Portage. Left to right, are: Dr. George E. Callentine, Milwaukee; Dr. Gerald A. Kerrigon, Milwaukee; Dr. Robert A. Starr, Viroqua; and Dr. Burton A. Waisbren, Milwaukee.

An excellent gift idea for special occasions all year around—for your wife, husband, or friends associated with the medical profession.

GIFT JEWELRY

Authentic reproductions of ancient coins, crafted into exquisite jewelry for both men and women, cast in metal and silver plated.

36ES—Earrings

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HEAD OF ASKLEPIOS
God of Medicine
36ES—Earrings
36Cl—Cuff Links

HEALING SERPENT STAFF
37ES—Eorrings
37Cl—Cuff Links

ASKLEPIOS COIN
36.7KC—Key Chain
36.7P—Pin

HEALTH DENARIUS
38ES—Earrings
38Cl—Cuff Links

SALUS COIN
Goddess of Health
39Cl—Cuff Links
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2.75 each
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THE MUSEUM OF MEDICAL PROGRESS
South Beaumont Road Prairie du Chien, Wiscansin

A project of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wiscansin

WPS Reports End Of Year Tabulations

Wisconsin Physicians Service, a division of the State Medical Society, has announced the renewal of health care coverage for two major groups in the state.

The State of Wisconsin employees group has renewed its coverage for the third successive year, effective April 1. WPS provides basic surgical-medical coverage for 18,300 of these employees and major medical coverage for 11,200.

The General Motors Company, with 5,100 employees, has also renewed its coverage for surgical-medical protection.

Both groups receive the Special Service "no fee schedule" coverage for basic surgical-medical protection.

Announcement of the renewals follows a year-end report which included a premium income of $9,707,643 for WPS, an increase of more than a half-million dollars over 1960. The goal for 1962 is set at $11 million.

Administrative expense was reduced from 12.08 per cent in 1960 to 11.63 per cent in 1961 and reserves or surplus increased by $561,814 to a total of $2,016,752 at the end of the year.

A.M.A. GIVES ANSWER ON PHYSICIAN ACTION IN FALLOUT AREAS

A North Carolina physician queried the American Medical Association on the ethical duties of physicians in "hot" fallout areas following an atomic attack.

"I am not sure I would be capable, even if I had an adequate shelter, of turning down requests for treatment," he stated.

An AMA consultant replied:

"Civil defense authorities agree that the physician is in the same category as everyone else regarding shelter protection from radioactive fallout. It would be short sighted for a physician to provide medical services to casualties in a 'hot' area that would in a short time incapacitate him to fulfill subsequent medical responsibilities.

"While this does not appear to be a question of ethics, the physician should recognize that all health services be conserved to provide maximum recovery from such a disaster."

News Briefs

NEW WPS NON-GROUP AGENT

The Berndt-Murat Insurance Agency, Stevens Point, has been named as non-group representative for Wisconsin Physicians Service, the health care plan of the State Medical Society.

This brings to 32 the number of agents selling individual and family WPS coverage in various communities in the state.

A.M.A. OFFERS FILM AIDS

The American Medical Association's 16-year program of disseminating information on new medical motion pictures reached a coveted milestone this winter with the publication in the *Journal of the AMA* of the 1,000 film review.

The reviews are especially valuable to medical educators and program chairmen in planning medical meetings and hospital staff conferences.

The AMA maintains a film library of 1,253 prints of 268 different subjects and booked a total of 10,025 showings in 1961.

Assistance in obtaining desired films is offered by the State Medical Society, or physicians may write directly to the American Medical Association.

SET STATE MEDICAL GOLF TOURNAMENT

Almost 200 golfers are expected to participate in the 1962 Spring Tournament of the Wisconsin State Medical Golf Association at Tuckaway Country Club, Milwaukee, on Monday, May 7, the first day of the annual meeting of the State Medical Society.

Tournament activity will include golf and dinner with golf play beginning at 10:30 a.m. and dinner at 7:30 p.m.

Reservations for golf and dinner at $14 per person can be made directly to the Wisconsin State Medical Golf Association, A. H. Luthmers, Executive Secretary, 756 North Milwaukee Street, Milwaukee 2, Wisconsin.

Welfare Study Compares Health Vendor Payments

Results of a study of the distribution of health care payments to vendors by the Department of Public Welfare, on behalf of social security aid recipients, indicates a trend for greater use of public medical institutions over nursing homes.

The study, recently released, compared payments during May 1961 with those of October 1958.

All categories of vendors show an increase in total payments; it is in the percentage distribution that the variation between the two survey periods appears.

Following are the figures comparing the two periods in the studies:

Type of vendor	*Expenditures*		*Percent distribution*	
	May 1961	*Oct. 1958*	*May 1961*	*Oct. 1958*
Total	$2,344,874	$1,587,060	100.0%	100.0%
Nursing homes	606,585	477,371	25.9	30.1
Public medical institutions	414,443	179,935	17.7	11.3
Hospitals	743,325	523,587	31.7	33.0
Physicians	268,832	186,847	11.4	11.8
Dentists	36,437	33,862	1.6	2.1
Pharmacists	190,619	121,634	8.1	7.7
Optometrical services	13,138	9,526	0.6	0.6
Other vendors	71,495	54,298	3.0	3.4

Education and Leadership for Progress in Wisconsin Medicine

STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING

MAY 8·9·10 1962

MILWAUKEE AUDITORIUM HOTEL SCHROEDER

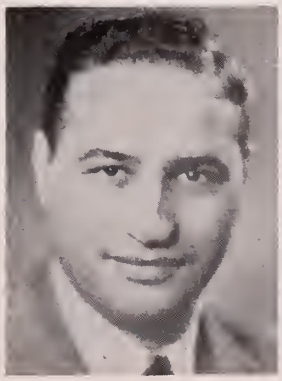
Milwaukee

Each year brings new discoveries and varying modes of therapy of concern to every alert physician. With this in mind, the Commission on Scientific Medicine has arranged a varied and interesting program for the 1962 Annual Meeting. Participation in this meeting by way of attendance is an important part of a physician's progress in medical knowledge.

ROY B. LARSEN, M.D.
Chairman, Commission on Scientific Medicine (left)

A. R. CURRERI, M.D.
Chairman, Round Table Luncheons (lower left)

R. W. FARNSWORTH, M.D.
Chairman, General Program (lower right)



1962 ANNUAL MEETING
TIMETABLE

MONDAY, MAY 7

All Day—Golf Tournament: Ozaukee Country Club
7:00 p.m.—House of Delegates at Milwaukee Auditorium

TUESDAY, MAY 8

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Milwaukee Auditorium
9:30 a.m.—General Scientific Program, Milwaukee Auditorium
9.30 a.m.—Program on Internal Medicine, Milwaukee Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Marq. U. and U. of W. medical school's alumni luncheons at Auditorium
2:00 p.m.—Section Meetings on Internal Medicine, Obstetrics and Gynecology, Pathology and Psychiatry at Auditorium
6:00 p.m.—Buffet for Delegates and Officers at Milwaukee Auditorium
7:30 p.m.—House of Delegates at Milwaukee Auditorium

WEDNESDAY, MAY 9

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—House of Delegates at Milwaukee Auditorium
9.30 a.m.—General Practice Program at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and members of SMS Charitable, Educational and Scientific Foundation at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association at Milwaukee Athletic Club
2:00 p.m.—Section Meetings on Orthopedic Surgery and Pediatrics at Auditorium
2:00 p.m.—Conference on "Medical Aspects of Sports," Milwaukee Auditorium
6:15 p.m.—President's reception
7:15 p.m.—Annual dinner

THURSDAY, MAY 10

8.00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:30 a.m.—Clinic on Dermatology and Allergy at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past president's luncheon
1:00 p.m.—Program on Ophthalmology and Otolaryngology at Hotel Schroeder
2:00 p.m.—Section Meetings on Anesthesia, Radiology, and Surgery at Auditorium

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

Roy B. Larsen, M.D.——Wausau
Chairman
Richard Farnsworth, M.D.——Janesville
General Program Chairman
Anthony R. Curreri, M.D.——Madison
Round Table Luncheons
P. T. Bland, M.D.——Westby
Scientific Exhibits
G. E. Collentine, Jr., M.D.——Milwaukee
Special Assignments
Philip P. Cohen, M.D.——Madison
Acting Dean, University of Wisconsin Medical School
John S. Hirschboeck, M.D.——Milwaukee
Dean, Marquette University School of Medicine
V. S. Falk, Jr., M.D.——Edgerton
Medical Editor, *The Wisconsin Medical Journal*

★ ★ ★

★ **REGISTRATION:** Pick up your badge at the registration desk, inside of main entrance of Milwaukee Auditorium, Fifth and Kilbourn Streets. The time Tuesday, 8:00 a.m.–4:30 p.m.; Wednesday and Thursday, 8:00 a.m.–4:00 p.m. Admittance by badge only.

★ **CERTIFIED GUESTS:** Medical students, medical assistants and hospital personnel will be admitted on Wednesday, May 9, after 12:00 noon, or Thursday, May 10, between 9:00 a.m. and 3:00 p.m. Interns and residents admitted without registration fee, if certified by hospital. Members of the Wisconsin State Dental Society and out-of-state physicians who are members of their county and state medical societies admitted by membership cards.

★ **VA AND M.D.'s IN MILITARY SERVICE:** *Members of the Veterans Administration must be members of the State Medical Society to be admitted.* Physicians in the armed services admitted by presenting certification of current military status.

BEFORE LEAVING FOR MEETING

GIVE YOUR SECRETARY THIS INFORMATION

TELEPHONE SERVICE: Registration Desk, Milwaukee Auditorium—**BR 1–9609.** *For Milwaukee MDs, Direct call through BR 1–4131 and it will be relayed to a special phone near the main meeting hall at the Auditorium.* For those at Luncheons: 5th Floor Foyer phone at Hotel Schroeder—BR 1–7250. Tell your secretary the room number of the luncheon, so we can locate you!

PRESS and STAFF ROOM
in South Kilbourn Hall of
MILWAUKEE AUDITORIUM

MILWAUKEE AUDITORIUM

PROGRAM • ANNUAL MEETING

May 8, 9, 10, 1962 • Milwaukee Auditorium • Hotel Schroeder

MONDAY, MAY 7

P.M.

6:30—REGISTRATION OF THE HOUSE OF DELEGATES
5th Street Foyer, Milwaukee Auditorium

7:00—FIRST SESSION: HOUSE OF DELEGATES
Juneau Hall, Milwaukee Auditorium
(Entrance at 5th Street)

HOUSE OF DELEGATES

Meetings of the House of Delegates are regarded as among the most important functions of the Annual Meeting of the State Medical Society. Reports of the officers and committees, as well as new business, will be presented at the initial session of the House at 7:00 p.m., Monday, May 7.

ALL MEETINGS OF THE HOUSE AND REFERENCE COMMITTEES WILL BE HELD AT MILWAUKEE AUDITORIUM
(rather than Hotel Schroeder as in the past)

TUESDAY, MAY 8

A.M.

8:00—REGISTRATION AND OPENING OF SCIENTIFIC AND TECHNICAL EXHIBITS
Registration: Kilbourn St. Entrance: Milwaukee Auditorium
Exhibits in Bruce Hall and on Stage: Milwaukee Auditorium

9:00—REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES

COMMITTEE ON NOMINATIONS:
Committee Room "B," Milwaukee Auditorium

COMMITTEE ON RESOLUTIONS:
Committee Room "A," Milwaukee Auditorium

COMMITTEE ON REPORTS OF OFFICERS:
Committee Room "D," Second Floor, Milwaukee Auditorium

COMMITTEE ON REPORTS OF STANDING COMMITTEES:
Committee Room "C," Second Floor, Milwaukee Auditorium

All those concerned with work of these committees, who wish to express their views on reports or resolutions to be acted upon at the second session of the House, on Tuesday evening, are asked to please appear before the appropriate Reference Committee **before noon on Tuesday,** so proper reports can be prepared on Tuesday afternoon.

TUESDAY MORNING

9:30 to 12:00

Your Female Patient and Special Problems She Presents

Arranged in cooperation with the Wisconsin Society of Obstetrics and Gynecology

PLANKINTON HALL
Milwaukee Auditorium

9:30—ENDOCRINE ASPECTS OF ENDOMETRIAL ADENOCARCINOMA

Moderator: **Richard F. Mattingly,** M.D., Milwaukee, Professor and Chairman of the Department of OB and Gyn, Marquette University School of Medicine.

Participants: **Robert E. Scully,** M.D., Boston
Edmund R. Novak, M.D., Baltimore

10:15—RECESS TO VIEW EXHIBITS

11:00—THE MEDICAL AND SURGICAL COMPLICATIONS OF PREGNANCY AND THE ROLE OF THE INTERNIST

Moderator: **Ben M. Peckham,** M.D., Madison, Professor and Chairman of the Department of OB & Gyn, University of Wisconsin Medical School

Participants: **Alan Guttmacher,** M.D., New York City; **Ralph Reis,** M.D., Chicago; **Charles L. Junkerman,** M.D., Milwaukee

9:30 to 11:45

Special Program on Cardiology

Arranged in cooperation with the Wisconsin Society of Internal Medicine

ENGELMANN HALL
Milwaukee Auditorium

Moderator: **Leslie G. Kindschi,** M.D., Monroe, President, Wisconsin Society of Internal Medicine

9:30—ACUTE DIFFUSE VIRAL MYOCARDITIS

Robert A. Miller, M.D., Chicago

10:00—Discussion and Questions

10:15—RECESS TO VIEW EXHIBITS

10:45—SURGICAL TREATMENT OF CONGENITAL HEART DISEASE

Ormand C. Julian, M.D., Chicago

11:30—THE INTELLIGENT USE OF THE SGOT AND LDH TESTS IN ACUTE MYOCARDIAL INFARCTION

John H. Huston, M.D., Milwaukee

(Lecture sponsored by Wisconsin Chapter, American College of Chest Physicians)

Edmund R. Novak, M.D.
Baltimore

Robert E. Scully, M.D.
Boston

Ralph A. Reis, M.D.
Chicago

Alan Guttmacher, M.D.
New York City

TUESDAY 12:15 NOON

(See page 220 for reservation form for Round Table Luncheons)

Alumni Luncheons

MILWAUKEE AUDITORIUM

1. **Marquette University School of Medicine Alumni Association**

   Market Hall (Basement of Auditorium): $2.50 Send reservations to Mr. Ray Pfau, 620 North 14th Street, Milwaukee 3, Wis.

2. **University of Wisconsin Medical School Alumni Association**

   South Juneau Hall (Milwaukee Auditorium): $3.50 (including social hour). Speaker: **Robert Sachs,** Professor of Physics, University of Wisconsin, "The Nature of the Atomic Weapon." Reservations to: Mr. Ralph Hawley, Medical Alumni office, 418 North Randall Ave., Madison 6, Wis.

Round Table Luncheons

HOTEL SCHROEDER

1. **THE EMERGENCY TREATMENT OF THE COMPLICATIONS OF CORONARY OCCLUSION**
   Arthur M. Master, M.D., New York City
   Moderator: Leslie G. Kindschi, M.D., Monroe
   East Room: 5th Floor, Hotel Schroeder

2. **ENDOMETRIOSIS**
   Ralph A. Reis, M.D., Chicago
   Moderator: Ben M. Peckham, M.D., Madison
   English Room: 5th Floor, Hotel Schroeder

3. **HORMONAL CYTOLOGY**
   George L. Wied, M.D., Chicago
   Moderator: Frank J. Glassy, M.D., Marshfield
   Pere Marquette Room: 5th Floor, Hotel Schroeder

4. **PROBABLE EFFECT OF COMMUNITY AGENCIES ON THE PERSONALITY DEVELOPMENT OF CITIZENS**
   Maurice E. Linden, M.D., Philadelphia
   Moderator: Harold N. Lubing, M.D., Madison
   Room 507: 5th Floor, Hotel Schroeder

John Severinghaus, M.D.
San Francisco

Arthur M. Master, M.D.
New York City

George L. Wied, M.D.
Chicago

Maurice E. Linden, M.D.
Philadelphia

R. W. Hollenhorst, M.D.
Rochester, Minn.

Walter P. Work, M.D
Ann Arbor, Mich.

A. Rostenberg, Jr., M.D.
Chicago

John A. Evans, M.D.
New York City

TUESDAY AFTERNOON

2:00 — MILWAUKEE AUDITORIUM

Special Teaching Programs

1. **INTERNAL MEDICINE**—ENGELMAN HALL
   Moderator: **Leslie G. Kindschi,** M.D., Monroe

   2:00—THE MASTER '2-STEP' EXERCISE ELECTROCARDIOGRAM
   Arthur M. Master, M.D., New York City
   (Lecture Sponsored by Wisconsin Heart Association

   2:45—Questions and Discussion

   3:00—RECESS TO VIEW EXHIBITS

   3:45—METHEMOGLOBINEMIA AND HEMOLYTIC ANEMIA
   Ennio Rossi, M.D., Madison, University of Wisconsin Medical School (Sponsor: Robert F. Schilling, M.D.)

   4:00—(copy coming)

   4:15—RESPONSES TO SMALL DOSES OF FOLIC ACID IN PERNICIOUS ANEMIA
   J. J. Chosy, M.D., Madison, University of Wisconsin Medical School (Sponsor: Robert F. Schilling, M.D.)

2. **OBSTETRICS AND GYNECOLOGY**—PLANKINTON HALL
   Moderator: **A. A. Cantwell,** M.D., Shawano, President, Wisconsin Society of Obstetrics and Gynecology

   2:00—CESAREAN SECTION IN TWIN PREGNANCY
   Alan Guttmacher, M.D., New York City

   2:45—THE STEIN-LEVENTHAL SYNDROME
   Edmund R. Novak, M.D., Baltimore

   3:15—RECESS TO VIEW EXHIBITS

   3:45—INDUCTION OF LABOR: PRO AND CON
   Alan Guttmacher, M.D., New York City
   Ralph A. Reis, M.D., Chicago

3. **PATHOLOGY**—NORTH KILBOURN HALL
   Moderator: **Frank J. Glassy,** M.D., Marshfield, President, Wisconsin Society of Pathologists

   2:00—THE MECHANICS OF CARCINOGENESIS
   Joseph F. Kuzma, M.D., Milwaukee

   2:30—DIFFERENTIATION OF CERVICAL LESIONS (Dysplasia, Carcinoma in situ, and Invasive Carcinoma) BY MEANS OF CYTOMETRY AND ROUTINE CYTOLOGICAL EXAMINATIONS
   George L. Wied, M.D., Chicago

   3:00—RECESS TO VIEW EXHIBITS

   3:45—GERM CELL TUMORS OF THE OVARY
   Robert Scully, M.D., Boston

4. **PSYCHIATRY**—WALKER HALL
   Moderator: **C. L. Kline,** M.D., Wausau, Program Chairman, Wisconsin Psychiatric Association

   2:00—FAMILY ORGANIZATION AND MODERN CHARACTER DEVELOPMENT
   Maurice E. Linden, M.D., Philadelphia
   (Rogers Memorial Lecture sponsored by Rogers Memorial Hospital, Oconomowoc)
   Discussant: **Edward E. Houfek,** M.D., Sheboygan

   2:45—Questions and Discussion

   3:00—RECESS TO VIEW EXHIBITS

   3:45—HOW CAN YOU HELP CHILDREN AND PARENTS
   (Panel)
   Moderator: **Carl L. Kline,** M.D., Wausau
   Participants: **Harold F. Borenz,** M.D., Madison; **William C. Lewis,** M.D., Madison; **Charles R. Headlee,** M.D., Milwaukee; **Robert E. O'Connor,** M.D., Madison

TUESDAY NIGHT

5:30—ANNUAL DINNER MEETING, Chest Physicians **(see page 210 for details)**

6:00—BUFFET DINNER FOR DELEGATES AND OFFICERS
Market Hall: Milwaukee Auditorium
(5th Street Entrance)

7:30—SECOND SESSION OF THE HOUSE OF DELEGATES
Juneau Hall: Milwaukee Auditorium

WEDNESDAY MORNING

MILWAUKEE AUDITORIUM

8:00—REGISTRATION: Kilbourn Street Entrance: Milwaukee Auditorium

8:00—EXHIBIT REVIEW: Scientific and Technical
Bruce Hall, Milwaukee Auditorium

9:00—THIRD SESSION OF THE HOUSE OF DELEGATES
Juneau Hall, Milwaukee Auditorium

9:30—EXTERNAL CARDIAC MASSAGE
See details below.

11:30—CLINICAL TRIALS WITH LIVING ATTENUATED MEASLES vs VIRUS VACCINE
Fred R. McCrumb, Jr., M.D., Baltimore
(Lecture sponsored by Wisconsin State Board of Health)

9:30 A. M.

External Cardiac Massage

MOVIES • COMMENTS • DEMONSTRATIONS

(Program arranged in cooperation with the Wisconsin Academy of General Practice. Participation in this program and afternoon programs will provide 6 hours of Category I credit for A.A.G.P. members)

Moderator: **A. H. Stahmer,** M.D., Wausau, President, Wisconsin Academy of General Practice

1. **Movies with comments on MOUTH-TO-MOUTH RESUSCITATION and EXTERNAL CARDIAC MASSAGE**
   Karl Siebecker, M.D., Madison
2. **Demonstration of technique**
   Karl Siebecker, M.D., Madison
   (Individual instruction in afternoon—see below)
3. **THE EXTERNAL AFIBRILLATOR**
   John H. Huston, M.D., Milwaukee

IMPORTANCE OF ATTENDANCE! Because local groups of firemen, lifeguards, law enforcement officers, etc. will request M.D. instruction in this technique, it is important that **every hospital staff in the state** has at least one M.D. in attendance at the morning program and at one of the instructional periods noted below.

DEMONSTRATIONS ON EXTERNAL CARDIAC MASSAGE
COMMITTEE ROOM D—Across corridor of Plankinton Hall, 2nd floor
WEDNESDAY—2:00 to 5:00 p.m.
THURSDAY—9:00 to 12:00 a.m.

WEDNESDAY 12:15 NOON

(See page 220 for reservation form for Round Table Luncheons)

Round Table Luncheons
HOTEL SCHROEDER

1. **PHYSIOLOGICAL EVENTS PRECEDING STEROID-INDUCED DIURESIS IN NEPHROSIS**
   William J. Oliver, M.D., Ann Arbor Michigan
   Moderator: E. H. Pawsat, M.D., Fond du Lac
   English Room: 5th Floor, Hotel Schroeder

2. **PRESENT STATUS OF ANTIBIOTIC THERAPY**
   Burton A. Waisbren, M.D., Milwaukee
   Room 507: 5th Floor, Hotel Schroeder

3. **ROLE OF EMBOLI IN PRODUCING LIMB ISCHEMIA**
   A. W. Humphries, M.D., Cleveland
   Moderator: **James E. Miller,** M.D., Madison
   Room 508: 5th Floor, Hotel Schroeder

4. **REHABILITATION IN ARTHRITIS (Panel)**
   Moderator: **M. C. Borman,** M.D., Milwaukee
   Participants: **Gerson C. Bernhard,** M.D., Milwaukee; **Owen B. Miller,** M.D., Milwaukee; and **Edwin C. Welsh,** M.D., Milwaukee
   Parlor A: 4th Floor, Hotel Schroeder

5. **NEWER DRUGS AND THEIR USES**
   Ovid Meyer, M.D., Madison
   Parlor C: 4th Floor, Hotel Schroeder

6. **DYSMENORRHEA**
   Edmund R. Novak, M.D., Baltimore
   Moderator: Richard F. Mattingly, M.D., Milwaukee
   Parlor D: 4th Floor, Hotel Schroeder

7. **MEASLES AND MEASLES PROPHYLAXIS (Including Measles Encephalitis)**
   Fred R. McCrumb, Jr., M.D., Baltimore
   Moderator: Carl N. Neupert, M.D., Madison
   Parlor E: 4th Floor, Hotel Schroeder

8. **SPECIAL LUNCHEON**
   Charitable, Educational and Scientific Foundation
   Pere Marquette Room: 5th Floor, Hotel Schroeder
   Reports and election of officers. Each county chairman expected to be in attendance. **No charge for luncheon.**

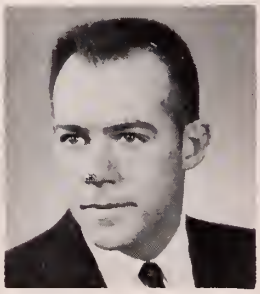
Chester B. McVay, M.D.
Yankton, S. Dak.

Donald E. Cassels, M.D.
Chicago

Fred R. McCrumb, Jr. M.D.
Baltimore

Alfred W. Humphries, M.D.
Cleveland

Joseph M. Janes, M.D.
Rochester, Minn.



William J. Oliver, M.D.
Ann Arbor, Mich.

Leon Goldman, M.D.
Cincinnati

Vincent J. Collins, M.D.
Chicago

WEDNESDAY AFTERNOON

2:00 — MILWAUKEE AUDITORIUM

Special Teaching Programs

1. PEDIATRICS—SOUTH KILBOURN HALL

Moderator: **Lloyd Williams,** M.D., Appleton, Program Chairman, Wisconsin Academy of Pediatrics

2:00—DIAGNOSIS AND TREATMENT OF RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE

Donald E. Cassels, M.D., Chicago

2:30—PROBLEMS IN THE DIAGNOSIS AND TREATMENT OF ACUTE NEPHRITIS IN CHILDREN

William T. Oliver, M.D., Ann Arbor, Michigan

3:00—CHILDREN'S PERSONALITY REACTION TO CHRONIC DISEASE

Harold F. Borenz, M.D., Madison

3:20—RECESS TO VIEW EXHIBITS

3:45—PEDIATRIC CLINIC ON RHEUMATIC HEART DISEASE AND NEPHRITIS

Cases Presented for Discussion by **Kenneth J. Winters,** M.D. and Associates on the Staff of Children's Hospital.

2. ORTHOPEDIC SURGERY—WALKER HALL

Moderator: **James E. Miller,** M.D., Madison, President, Wisconsin Orthopedic Society

2:00—AMPUTATION IN OCCLUSIVE VASCULAR DISEASE

Joseph M. Janes, M.D., Rochester, Minnesota

2:30—AMPUTATIONS: FROM THE VIEWPOINT OF THE INTERNIST

Robert Frisch, M.D., Milwaukee

3:00—RECESS TO VIEW EXHIBITS

3:45—REVERSIBILITY OF PRE-GANGRENE IN THE SEVERELY ISCHEMIC LIMB

Alfred W. Humphries, M.D., Cleveland

3. SPECIAL M.D. CONFERENCE ON "MEDICAL ASPECTS OF SPORTS"

PLANKINTON HALL

All physicians directly associated with high school athletic programs are urged to attend this conference. The conference is designed for physicians and high school administrators who wish to be informed as to the views expressed at the conference.

(Conference Sponsored by the Division on School Health, in cooperation with the Wisconsin Interscholastic Athletic Association.)

Moderator: **James C. H. Russell,** M.D., Fort Atkinson

A. THE PHYSICAL EXAMINATION FOR HIGH SCHOOL SPORTS PARTICIPANTS

Participants: **Fred V. Hein,** Ph.D., Chicago, Ill., and **William H. Bartlett,** M.D., Madison

B. WITHHOLDING PARTICIPANTS FROM SPORTS AND RETURN TO COMPETITION

Robert Murphy, M.D., Columbus, O.

Discussants: **George Collentine,** M.D., Milwaukee; **William H. Bartlett,** M.D., and **David Williams,** M.D., Madison

(See additional information on page 211)

EXTERNAL CARDIAC MASSAGE

Demonstration and explanation with manikin

KARL SIEBECKER, M.D., Madison, and **JOHN HUSTON,** M.D., Milwaukee

COMMITTEE ROOM D—opposite Plankinton Hall

2:00 to 5:00 p.m.

WEDNESDAY NIGHT

6:30—PRESIDENT'S RECEPTION: (For those attending Annual Dinner)

East Room, Hotel Schroeder, 5th Floor

7:15—ANNUAL DINNER:

Ballroom, Hotel Schroeder, 5th Floor

THURSDAY MORNING

MILWAUKEE AUDITORIUM

8:30—REGISTRATION

Kilbourn Street Entrance, Milwaukee Auditorium

8:30—SCIENTIFIC AND TECHNICAL EXHIBITS

Bruce Hall, Milwaukee Auditorium

9:00—EXTERNAL CARDIAC MASSAGE DEMONSTRATIONS

Committee Room D—opposite Plankinton Hall, 2nd Floor, Auditorium

Karl Siebecker, M.D., Madison; and **John Huston,** M.D., Milwaukee

9:30–12:00

Wet Clinic on Dermatology and Allergy

South Juneau Hall

Moderators: **Sture A. M. Johnson,** M.D., Madison (Dermatology); **Harry R. Weil,** M.D., Milwaukee (Allergy)

Cases presented through **Donald M. Ruch,** M.D., Milwaukee, for the Wisconsin Society of Dermatology, and **Harry Weil,** M.D., Milwaukee, for the Wisconsin Society of Allergists.

Discussants: **Leon Goldman,** M.D., Cincinnati, and **Adolph Rostenberg, Jr.,** M.D., Chicago

(The dermatologic portion of the Clinic will run from 9.30–10:15 a.m., and following the recess period from 10:15–10:45 a.m., cases on allergy will be presented from 10:45–11:30 a.m. The period from 11:30–12:00 noon will be used for discussion and comments by the two moderators.)

(continued from page 206)

TUESDAY NIGHT, MAY 8

5:30—ANNUAL DINNER MEETING, Wisconsin Chapter of the American College of Chest Physicians

English Room, Hotel Schroeder

7:30—SCIENTIFIC MEETING, Wisconsin Chapter of the American College of Chest Physicians

Speaker. **Arthur M. Olsen, M.D.:** Professor of Medicine, Mayo Foundation, University of Minnesota; Chairman, Board of Regents, American College of Chest Physicians

Lecture: **DYSPNEA**

(Guests are welcome to both the dinner and the scientific session. For reservations contact John H. Huston, M.D., President of the Wisconsin Chapter, 8700 West Wisconsin Avenue, Milwaukee 13, Wis.; phone BLuemound 8–2040)

THURSDAY 12:15 NOON

(See page 220 for reservation form for Round Table Luncheons)

Round Table Luncheons
HOTEL SCHROEDER

1. **CHOLANGITIS**
   C. B. McVay, M.D., Yankton, South Dakota
   Moderator: Paul F. Hausmann, M.D., Milwaukee
   English Room: 5th Floor, Hotel Schroeder

2. **NEWER ROENTGEN METHODS IN EXAMINATION OF KIDNEY**
   John A. Evans, M.D., New York City
   Moderator: John H. Juhl, M.D., Madison
   Pere Marquette Room: 5th Floor, Hotel Schroeder

3. **SOME CONSIDERATIONS OF METHODS FOR INCREASING THE EFFECTIVENESS OF TOPICAL CORTICOSTEROID PREPARATIONS**
   Leon Goldman, M.D., Cincinnati
   Moderator: G. A. Cooper, M.D., Madison
   Room 507: 5th Floor, Hotel Schroeder

4. **PATCH TESTING: INDICATIONS AND TECHNIQUES**
   Adolph Rostenberg, Jr., M.D., Chicago
   Moderator: Frederick O. Kuehl, M.D., Green Bay
   Room 508: 5th Floor, Hotel Schroeder

5. **THE ANESTHESIOLOGIST AS RESPIRATORY CONSULTANT**
   John Severinghaus, M.D., San Francisco
   Moderator: J. Jay Jacoby, M.D., Milwaukee
   Parlor A: 4th Floor, Hotel Schroeder

6. **THE THEOPHYLLINE DRUGS**
   Harry Beckman, M.D., Milwaukee; and **Harold G. Hardman,** M.D., Milwaukee
   Parlor D: 4th Floor, Hotel Schroeder

7. **INFERTILITY: ETIOLOGICAL FACTORS AND MANAGEMENT**
   Richard F. Mattingly, M.D., Milwaukee
   Parlor E: 4th Floor, Hotel Schroeder

8. **SPECIAL LUNCHEON**
   Past Presidents
   Parlor G: 4th Floor, Hotel Schroeder

12:15—LUNCHEON AND SCIENTIFIC PROGRAM OF THE SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

EAST ROOM: HOTEL SCHROEDER

Moderator: **Howard C. High,** M.D., Milwaukee
Chairman, Section on Obstetrics and Gynecology

12:15—Luncheon

1:00—Business Meeting

2:00—CANCER OF THE LARYNX
Walter P. Work, M.D., Ann Arbor, Michigan

2:45—TEMPORAL ARTERITIS
Robert W. Hollenhorst, M.D., Rochester, Minn.

(continued from page 209)

Medical Aspects of Sports

WEDNESDAY 2:00 P.M.

PLANKINTON HALL, MILWAUKEE AUDITORIUM

All physicians directly associated with high school athletic programs are urged to attend this conference. This will be an exchange of views designed to assist physicians and high school administrators in carrying out athletic programs.

Fred V. Hein, Ph.D
Chicago, Ill.

"Withholding Participants from Sports and Return to Competition"

Robert J. Murphy, M.D.
Columbus, Ohio

"The Physical Examination for High School Sports Participants"

THURSDAY AFTERNOON

2:00 — MILWAUKEE AUDITORIUM

Special Teaching Programs

1. ANESTHESIOLOGY— SOUTH KILBOURN HALL

Moderator: **John L. McClung,** M.D., Madison, President, Wisconsin Society of Anesthesiologists

2:00—NEUROLOGICAL COMPLICATIONS DURING GENERAL ANESTHESIA
Vincent J. Collins, M.D., Chicago

3:00—RECESS TO VIEW EXHIBITS

2:30—THE FIRST GASP
Thomas Meyer, M.D., resident at University of Wisconsin Medical School (Sponsor: Betty Bamforth, M.D.)

3:30—THE PULMONARY CIRCULATION
John W. Severinghaus, M.D., San Francisco

2. RADIOLOGY—WALKER HALL

Moderator: **John H. Juhl,** M.D., Madison, President, Wisconsin Radiological Society

2:00—BENIGN BONE TUMORS OF THE EXTREMITIES
David G. Pugh, M.D., Rochester, Minn.

2:30—ROENTGEN STUDIES IN CYSTIC DISEASE OF THE KIDNEYS
John A. Evans, M.D., New York City

3:00—RECESS TO VIEW EXHIBITS

3:30—HYSTEROGRAPHY WITH AN OBTUNDING CATHETER
Abraham Marck, M.D., Milwaukee

3:45—FORCEFUL, URETERAL SPURT—A COMMON ROENTGEN MANIFESTATION OF URINARY TRACT INFECTION IN CHILDREN
I. Nik Nevin, M.D., Rhinelander

4:10—WILMS' TUMOR, A STUDY OF TWENTY-NINE CASES
M. L. Hinke, M.D. and **Halvor Vermund,** M.D., Madison

4:30—Business Meeting, Section on Radiology of the State Medical Society

7:00—Dinner Meeting, Wisconsin Radiological Society—University Club. Speaker: **David G. Pugh,** M.D., Rochester, Minn. Subject: **SKELETAL CHANGES CAUSED BY RENAL DISEASE**

3. SURGERY—PLANKINTON HALL

(Official meeting of Wisconsin Surgical Society, but lecture portion of program open to any physician registered for the Annual Meeting. Business meeting for members of the Wisconsin Surgical Society only.)

Moderator: **Jack A. Killins,** M.D., Green Bay, President, Wisconsin Surgical Society

2:00—ABDOMINAL INCISIONS—A PHILOSOPHY
Chester B. McVay, M.D., Yankton, South Dakota

2:30—TORSION OF THE HYDATID OF MORGAGNI; REPORT OF THREE CASES
L. H. Stone, M.D., Oshkosh

2:40—TIMING OF OPERATION IN ACUTE CHOLECYSTITIS
Albert G. Martin, M.D., Milwaukee

3:00—RECESS TO VIEW EXHIBITS

3:10—PRESIDENTIAL ADDRESS
A. R. Curreri, M.D., Madison

3:20—SURVEY OF GASTRIC SURGERY
William B. Gallagher, M.D., La Crosse

3:40—A REAPPRAISAL OF TETANUS PROPHYLAXIS
Sam Harper, M.D., Madison

4:00—ANTERIOR CERVICAL FUSION IN THE MANAGEMENT OF CERVICAL SPINE FRACTURE DISLOCATION
Eugene Herzberger, M.D., Monroe

4:20—BILATERAL VOCAL CORD PARALYSIS AND ITS TREATMENT
E. J. Zmolek, M.D., Oshkosh

4:40—INTRALOBAR PULMONARY SEQUESTRATION
Robert G. Wochos, M.D. and **Charles Benkendorf,** M.D., Green Bay

OUT-OF-STATE GUEST LECTURERS
1962 Annual Meeting

DONALD E. CASSELS, M.D., Chicago
Professor of Pediatrics, University of Chicago Medical School

VINCENT J. COLLINS, M.D., Chicago
Director, Department of Anesthesia, Cook County Hospital

JOHN A. EVANS, M.D., New York City
Professor of Radiology, Cornell University Medical College

LEON GOLDMAN, M.D., Cincinnati
Professor of Dermatology, University of Cincinnati Medical School

ALAN GUTTMACHER, M.D., New York City
Chief of Obstetrics and Gynecology, Mt. Sinai Hospital; Clinical Professor of Obstetrics & Gynecology, Columbia University College of Physicians & Surgeons

R. W. HOLLENHORST, M.D., Rochester, Minnesota
Associate Professor of Ophthalmology, Mayo Foundation Graduate School (Univ. of Minnesota)

ALFRED W. HUMPHRIES, M.D., Cleveland
Associate Professor of Vascular Surgery, Frank E. Bunts Institute (Clev.)

ORMAND C. JULIAN, M.D., Chicago
Professor of Surgery, University of Illinois College of Medicine

MAURICE E. LINDEN, M.D., Philadelphia
Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine

ARTHUR M. MASTER, M.D., New York City
Consultant Cardiologist, The Mt. Sinai Hospital, New York, N. Y.

FRED R. McCRUMB, JR., M.D., Baltimore
Director, Division of Infectious Diseases, University of Maryland School of Medicine

CHESTER B. McVAY, M.D., Ph.D., Yankton, S.D.
Clinical Professor of Surgery, University of South Dakota Medical School; Associate Professor of Anatomy, University of South Dakota Medical School

ROBERT A. MILLER, M.D., Chicago
Assistant Professor of Pediatrics, Northwestern University School of Medicine

ROBERT MURPHY, M.D., Columbus, Ohio
Assistant Clinical Professor of Medicine, Ohio State University; Medical Consultant, Ohio Rehabilitation Center; Team Physician, Ohio State University, Department of Athletics

EDMUND R. NOVAK, M.D., Baltimore
Assistant Professor of Obstetrics & Gynecology, Johns Hopkins University School of Medicine

WILLIAM J. OLIVER, M.D., Ann Arbor
Assistant Professor of Pediatrics, University of Michigan Medical School

DAVID G. PUGH, M.D., Rochester, Minnesota
Professor of Radiology, Mayo Foundation Graduate School (University of Minnesota)

RALPH A. REIS, M.D., Chicago
Professor of Obstetrics & Gynecology, Northwestern University School of Medicine

ADOLPH ROSTENBERG, JR., M.D., Chicago
Professor of Dermatology and Chairman of the Department of Dermatology, University of Illinois College of Medicine

ROBERT E. SCULLY, M.D., Boston
Assistant Clinical Professor of Pathology, Harvard University School of Medicine

JOHN W. SEVERINGHAUS, M.D., San Francisco
Associate Professor of Anesthesiology, University of California Medical School

GEORGE L. WIED, M.D., Chicago
Associate Professor of Obstetrics & Gynecology, University of Chicago, and Director of Cytology, University of Chicago Hospitals

WALTER P. WORK, M.D., Ann Arbor, Michigan
Professor of Otolaryngology, University of Michigan Medical School

JOSEPH M. JANES, M.D., Rochester, Minnesota
Professor of Orthopedic Surgery, Mayo Foundation Postgraduate School, University of Minnesota

1962 SPRING TOURNAMENT OF THE WISCONSIN STATE MEDICAL GOLF ASSOCIATION AT TUCKAWAY COUNTRY CLUB, MILWAUKEE, MONDAY, MAY 7

Reservations for golf and dinner at $14 per person can be made directly to the Wisconsin State Medical Golf Association, A. H. Luthmers, Executive Secretary, 756 N. Milwaukee St., Milwaukee 2, Wis.

Scientific Exhibits

MILWAUKEE AUDITORIUM

THOSE LOCATED IN MAIN EXHIBIT HALL

P. T. BLAND, M.D.
Chairman
Scientific Exhibits

18—IDENTIFICATION OF THE CONDUCTION SYSTEM OF THE HEART

Drs. Derward Lepley, William Bormes, and Kenneth Kayser, B.S., Department of Surgery, Marquette University School of Medicine

This exhibit demonstrates a successful investigative effort to locate the conduction system of the heart so as to avoid heart block in open heart surgery. The electronic device employed includes an oscillator impedance bridge and a three-pole probe capable of measuring the impedance difference between the myocardium and the conduction system. The exhibit includes a description of the instrument, the results of animal experimentation and its clinical use in open heart surgery.

19—CASE PRESENTATIONS BY SMALL HOSPITAL STAFF

Staff of the Beaver Dam Hospitals, through the Beaver Dam Medical Forum

The physicians in and around Beaver Dam through an organization known as "The Beaver Dam Medical Forum" have sought to improve the medical care of the patient by greater dissemination of recent advances in medicine. This exhibit shows what alert physicians in a small community can do to stimulate professional inquiry. Four interesting cases are presented, showing the entire case from the point of case history to the pathologist's report. Staff members from smaller hospitals are urged to view this exhibit and discuss it with members of the Beaver Dam Medical Forum who will be in attendance.

47—THE HIP PROSTHESIS: ITS VARIOUS USES

Drs. Joseph R. Stone, Louis Kagen, and Paul A. Jacobs, Department of Orthopedic Surgery, Mt. Sinai Hospital, Milwaukee

In this exhibit the authors will show x-rays of pathological conditions (hips afflicted with Hodgkins disease, hypernephroma, nonunion of hip fractures, acute fractures of the hip, etc.) in which metal hips have been used for rehabilitation of these patients.

48—BLOCK THAT NERVE

Drs. Marvin Wagner and Sheldon Burchman, Department of Surgery, Mt. Sinai Hospital, Milwaukee

The exhibit will demonstrate anatomical diagrams of bicipital sulcus regional blocks for anesthesia for injuries of the upper extremity. The authors will also show demonstrations of the hazards with the brachial plexus block in the supra clavicular area, and the "Blind B lock" with the axillary approach.

48A—A DIABETIC INVENTORY

Dr. Edward H. Tashkin, Department of Internal Medicine, Mt. Sinai Hospital, Milwaukee

This exhibit will outline and emphasize the value of a complete inventory of the diabetic patient through a history, physical examination, clinical laboratory study and objective tests.

49—ROENTGEN EVALUATION OF SOLITARY "COIN" LESIONS

Drs. Morris Moel and L. K. Mark, Department of Radiology, Mt. Sinai Hospital, Milwaukee

The exhibit will present a variety of solitary pulmonary lesions representing many different conditions. The roentgenological findings, the differential diagnosis will be demonstrated with particular emphasis on the significance of the presence of calcification. The various roentgen techniques will be demonstrated and the limitation of roentgen examination will also be pointed out. Statistical analysis with reference to these lesions will be shown in an attempt to evaluate the presence of benign or malignant conditions.

50—(Copy to come)

76B—COSMETIC SURGERY

Dr. Sidney K. Wynn, Department of Surgery, Mt. Sinai Hospital, Milwaukee

This exhibit will include examples of cosmetic facial surgery, including examples of nasal plastics, eyelid plastics, ear plastics, prognathism, scar plastics, face lifting, and removal of some benign and malignant tumors on various facial areas, with immediate cosmetic reconstruction. With the exhibit will be over 100 photographs taken before, during, and after various types of surgical procedures to obtain these cosmetic results.

76A—THE VERSATILITY OF THE HEART-LUNG APPARATUS

Drs. A. H. Pemberton, M. M. Bortin, B. G. Narodick, Department of Cardiothoracic Surgery, Evangelical Deaconess Hospital, Milwaukee

The application of the heart-lung machine for open heart surgery is well documented. The same equipment may readily be adapted with or without hypothermia for extra-cardiac procedures such as brain and vascular surgery. It also may be utilized in cancer chemotherapy and for supportive treatment in both respiratory insufficiency and heart failure. The exhibit will illustrate the use of this equipment in the above situations.

76—CLINICAL STUDIES OF PROFOUND RELAXATION WITH MYLAXEN

Drs. R. R. Brazy, R. A. Schmidt, K. R. Fick, Department of Anesthesiology, Evangelical Deaconess Hospital, Milwaukee

The advantages, disadvantages and clinical experience with the use of the muscle relaxant drug Mylaxen are presented. The results of the use of Mylaxen in over 100 patients are included.

75—RADIOGRAPHIC DIFFERENTIATION OF HYPERTROPHIC EMPHYSEMA AND BRONCHIAL ASTHMA

Drs. Donald C. Ausman and Abraham Melamed, Department of Radiology, Evangelical Deaconess Hospital, Milwaukee

There are many times when the differentiation between hypertrophic emphysema and bronchial asthma is very difficult, particularly so when there is overlapping of clinical signs and symptoms and the usual roentgen examination of the chest is borderline. Because therapy in the two conditions can be widely divergent, it is necessary to establish the diagnosis with certainty.

Hyperinflation from any cause produces splaying and alteration in the angles of bifurcation of the pulmonary arterial tree. There are times when the medium and smaller branches of the pulmonary artery have in many segments disappeared or end abruptly before reaching the periphery of the lung. In asthma, the arterial caliber remains normal and there is a normal distribution of the arteries of both lungs.

Body section radiography provides a simple, reliable and relatively inexpensive technic for determining the course and caliber of the pulmonary vascular system. X-ray differentiation between hypertrophic emphysema and bronchial asthma is thus possible.

101—RADIOACTIVE LOCALIZATION OF BRAIN TUMORS

M. Javid, M.D., J. Cameron, Ph.D., and R. Grant, M.S., University of Wisconsin Medical School

The exhibit consists of explanatory charts, scintiscans, and photographs of the brain taken at the time of surgery. The method of administration of the radioisotopes and the techniques used in scinti-scanning will be illustrated. In addition, correlation of radiological diagnostic studies with scintiscans and the value of the latter as an aid to the neurosurgeon will be demonstrated.

102—PROTAMINE FOR LOWERING BLOOD AMMONIA

Drs. Henry Brown, Salah Yashruti, and Joseph Gale, and Julie Brown, B.S., Department of Surgery, University of Wisconsin Medical School

Although there are many factors associated with coma in liver failure, there is evidence that lowering blood ammonia can often ameliorate symptoms. The use of protamine for experimentally lowering blood ammonia will be demonstrated. Drawings and charts will show the method of performing a portacaval shunt, list clinical symptoms from elevated blood ammonia levels which may be relieved when ammonia is removed, and summarize experimental results with protamine.

103—ELECTROMYOGRAPHY FOR THE GENERAL PRACTITIONER

Dr. James F. McDermott and Staff, Physical Medicine and Rehabilitation Service, V.A. Center, Wood, Wisconsin, and the Department of Physical Medicine and Rehabilitation, Marquette University School of Medicine

The exhibit defines and illustrates basic electromyography potentials and lists common indications for this diagnostic procedure, using transparencies, schematic portrayal of the motor unit, and the resulting pattern on a facsimile of a cathode ray tube.

104—FETAL ELECTROCARDIOGRAPHY

Drs. Jack A. Klieger and Richard Mattingly, St. Joseph's Hospital, Milwaukee, and the Department of Obstetrics & Gynecology, Marquette University School of Medicine; and S. D. Larks, Ph.D., Department of Bio-Physics, Marquette University School of Engineering

The exhibit will contain reproductions of actual fetal electrocardiograms indicating such things as early diagnosis of pregnancy, multiple pregnancies, congenital heart disease and fetal distress. There will be a recorder in the exhibit, transcribing instantly a fetal electrocardiogram being taken on a pregnant patient at St. Joseph's Hospital.

105—COMPLETE UTERINE PROLAPSE IN GERIATRIC GYNECOLOGY TREATED BY VAGINAL HYSTERECTOMY AND VAGINECTOMY

Drs. F. J. Hofmeister and C. W. Wolfe, Milwaukee Hospital, Milwaukee

This exhibit demonstrates a method of dealing with complete prolapse of the uterus or complete prolapse of the vaginal vault where the uterus has been previously removed in the geriatric patient. This procedure though used only in a relatively few instances is extremely valuable when infirmity and degree of prolapse together with marital status and age indicate the necessity for complete repair without hazard of recurrence and without consideration of vaginal usage. Vaginal hysterectomy and vaginectomy eliminate the potential problems of recurrence and the retention of uterine pathology inherent in the antiquated Le Forte type procedure.

106—UTERUS TO URETER—MARGIN OR SAFETY?

Drs. F. J. Hofmeister, Richard C. Wolfgram and Walter Schwartz, Milwaukee Hospital, Milwaukee

The distance measurements between ligatures on vaginal hysterectomy pedicles and the ureters has been recorded under actual working conditions by radiographically identifying the ligatures of the pedicles with radiopaque material and hysterectomy clamp and the ureters with intravenous pyelogram and ureteral catheters. The procedure is demonstrated first by serial x-ray recording and finally visualization with the use of Heaney hysterectomy clamps and ureteral catheters by cinefluorographic demonstration.

107—CAROTID STENOSIS—STROKE SYNDROME

Drs. Harry P. Maxwell, Wayne J. Boulanger, James E. Conley, and Robert W. Byrne, Columbia Hospital, Milwaukee

Cases are presented to illustrate the clinical features of the various stroke syndromes caused by carotid stenosis. Illustrations include pre- and postoperative angiograms, operative procedures, and gross and microscopic pathology.

108 and 109—LESIONS OF THE CENTRAL NERVOUS SYSTEM

Wisconsin Society of Pathologists, in conjunction with the Department of Pathology, Marquette University School of Medicine

The format of the exhibit by the Wisconsin Society of Pathologists will be changed from that of previous years. The exhibit this year, 1962, will stress various central nervous system lesions. Some of the lesions will be demonstrated grossly in fixed tissue and by macroslide preparations on a viewbox. Other lesions may only be demonstrated by the macroslide viewbox projection. The specimens are a collection of various central nervous system lesions as gathered from various hospitals in the area. Dr. Andrew Cyrus of the Department of Pathology, Section of Neuropathology, at the University of Marquette School of Medicine is preparing the specimens. There may be room for a display case of various fresh tissue pathologic lesions but primarily the exhibit will center around lesions of the central nervous system.

110—CONVULSIONS IN INFANTS WITH GASTROENTERITIS

Dr. Gerald A. Kerrigan, Milwaukee Children's Hospital, Milwaukee

This exhibit will present by means of charts and legends some of the important causes of convulsions in infants with gastroenteritis and severe dehydration. Illustrative cases which have been studied by metabolic techniques will be used. The following conditions will be emphasized:

1. Convulsions due to water intoxication
   (a) With low serum sodium concentration
   (b) With high serum sodium concentration
2. Convulsions due to sodium loading, intracellular water depletion, and subdural bleeding
3. Convulsions due to hypocalcemia and the relation of sodium loading and potassium depletion to the pathogenesis of hypocalcemia

The pathogenesis of these abnormal states, the recognition of convulsion due to these metabolic disturbances, and their clinical management will be pointed out.

111—INVESTIGATION OF MALABSORPTION SYNDROME IN CHILDREN

Dr. Samuel R. McCreadie, and R. L. Arends, Ph.D., Milwaukee Children's Hospital, Milwaukee

By the way of charts and legends the exhibit will demonstrate the sites of absorption of specific types of nutriment in the gastrointestinal tract, and will outline the means of specifically identifying the defect in absorption. The substances involved will include glucose, inorganic iron, folic acid, fat, protein, and vitamin B_{12}, and the methods of study will be illustrated. The intestinal biopsy capsule and its use will be featured. Illustrative cases will be cited.

112—LABORATORY IDENTIFICATION OF GENETIC DEFECTS

R. L. Arends, Ph.D., and Drs. S. Berlow and S. R. McCreadie, Milwaukee Children's Hospital, Milwaukee

By use of viewboxes the exhibit will demonstrate the analysis of urine for abnormal excretory products, analysis of serum, analysis of red cells, examination of tissues, and identification of chromosomal abnormalities. Illustrative cases will be presented.

113—CONTINUOUS MURMURS OF CHILDHOOD

Dr. William J. Gallen, Milwaukee Children's Hospital, Milwaukee

The exhibit provides a description and graphic demonstration of some of the causes of the continuous, or so-called "machinery", murmur heard in infancy and childhood. It includes films, history data, x-ray studies electrocardiograms, phonocardiograms, and nature of origin of patent ductus arteriosus, and other defects producing such murmurs.

114—TREATMENT OF BURNS IN A PRIVATE, GENERAL HOSPITAL

Drs. George Collentine, John Conway, Burton Waisbren, and W. J. Woloschek, St. Mary's Hospital, Milwaukee

By use of slides and illustrations the exhibit will describe the facilities, patients, techniques, and results of treating burns at this specialized center.

EXHIBITS AT FOOT OF STAGE

127A—WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY

The exhibit will present work of this organization, and how the members are of special service to physicians.

127—MAPLE BARK DISEASE

Dr. Dean A. Emanuel and F. J. Wenzel, B.S., Marshfield Clinic Foundation for Medical Education and Research, Marshfield Clinic, Marshfield

Clinical study, x-rays, and experimental studies involving maple bark disease, a granulomatous pneumonitis due to Coniosporium corticale will be presented. The term "maple bark disease" is used because of spores found beneath the bark of maple logs that were noted to produce severe interstitial pneumonitis in a papermill worker. The illness was previously reported by Towey in 35 patients in 1932.

The disease mechanism is thought to be a local toxic effect combined with a delayed hypersensitivity reaction and resembles protein sensitization in its clinical and certain immunological aspects.

128—RADIOISOTOPES IN CLINICAL DIAGNOSIS

Staff of Milwaukee Hospital, Milwaukee

The exhibit will portray the several areas in which nuclear medicine can be adapted to the diagnosis of disease. It will illustrate and outline the principal procedures available in most institutions. These procedures have been shown to be of practical utility. The exhibit will summarize principles, results and interpretations.

129—PHYSICAL AND CHEMICAL TREATMENT OF RHEUMATIC DISORDERS

Dr. Ervin Hansher and Associates, Arthritis Center, St. Mary's Hospital, Milwaukee

The exhibit will outline methods used in the treatment of rheumatic disorders at the Arthritis Center of St. Mary's Hospital.

130—UNUSUAL ROENTGEN MANIFESTATIONS OF RHEUMATOID ARTHRITIS

Doctors Lee, Fitz, Sengpiel, and Wepfer, St. Joseph's Hospital, Milwaukee

Some of the unusual radiographic appearances of rheumatoid arthritis will be illustrated in this exhibit.

131—THIS IS ARTHRITIS?

Arthritis & Rheumatism Foundation, Wisconsin Chapter

The exhibit shows the progression of rheumatoid arthritis from the normal to the fusted joint.

134—IDENTIFICATION OF HEART SOUNDS

Wisconsin Heart Association

This exhibit was so well received in 1961 that the Wisconsin Heart Association was requested to again make it available for the 1962 Annual Meeting. By use of sound tapes of various abnormal heart sounds and murmurs, run through Cambridge equipment and permitting physicians to hear such sounds, the listener is able to test his ability to detect various types of abnormalities. The sounds will also be visible on an oscilloscope.

EXHIBITS IN HALLWAY LEADING TO MEETING ROOMS

135 and
136—(Copy to come)

SCIENTIFIC EXHIBITS ON THE STAGE OF BRUCE HALL

AUXILIARY HOSPITALITY CENTER AND ART SHOW

Be sure you visit the Auxiliary Hospitality Center, have a cup of coffee, and review the various watercolors and oils of Wisconsin MDs and their wives. BE SURE TO VOTE FOR THE PICTURE WHICH APPEALS TO YOU MOST!

EXAMINATION OF THE COLON AND RECTUM

American Cancer Society: Wisconsin and Milwaukee Divisions

A simple, but effective routine examination of the adult patient's lower colon and rectum is essential to the earlier diagnosis of precancerous and cancerous conditions therein. Wisconsin's higher than national average morbidity and mortality rates for colon cancer is another reason why diagnostic techniques are worth reviewing and renewing. Simple preparations of the colon, positions of the patient, technique of introduction and maneuvering of a scope, and overall results are considered.

YOUR ANSWER TO TB, DOCTOR

Wisconsin Anti-Tuberculosis Association, Dr. R. P. Jahn, Medical Director

The exhibit invites viewing physicians to answer several pertinent questions regarding the management of active tuberculosis cases and their contacts, as well as their opinion of certain current concepts about tuberculosis. Correct answers, and the reasoning behind them, will be supplied in pamphlet form. You are invited to test yourself!

SAVE A LIFE WITH SEAT BELTS

Division on Safe Transportation of the Commission on State Departments, State Medical Society of Wisconsin and the American Medical Association

The exhibit outlines the three reasons why people need an automobile seat belt, and answers the most common question concerning this safety factor in motoring.

THE UNWED PARENT

Dr. F. J. Hofmeister, in conjunction with Salvation Army

This exhibit summarizes a description of the services rendered by the Salvation Army homes for unwed mothers as indicated by a description of a patient's progress through the Martha Washington Home and Hospital in Wauwatosa, Wisconsin. Statistics concerning deliveries in the home and hospital are presented as well as a geographical indication of the location of homes in this territory.

MEDICINE AND SURGERY IN THE CIVIL WAR

Drs. William G. Gallagher and Edward Perry, Skemp Clinic and The Adolph Gundersen Medical Foundation, La Crosse

This interesting educational exhibit will feature slides made from photographs, line drawings, and etchings of Civil War physicians, aid stations, field hospitals, hospital trains, and hospital ships. The pictures coincide with the chronology of the war. There is a preliminary series of slides showing the general medical situation in the mid-nineteenth century in Europe and America. Slides to be accompanied by comments by the exhibitor. SHOWINGS DURING RECESS PERIODS EACH DAY OF THE ANNUAL MEETING.

Technical Exhibits

42—ABBOTT LABORATORIES, North Chicago, Ill.
87—AMES COMPANY, Elkhart, Ind.
60—ANDERSON PHARMACEUTICALS, Columbus, Ohio
21—ARMOUR PHARMACEUTICAL CO., Chicago, Ill.
31—AYERST LABORATORIES, Chicago, Ill.

17—ROBERT W. BAIRD CO., Milwaukee
126—BARR X-RAY CO., INC., Milwaukee
64—BENCO OPHTHALMIC LABORATORIES, Milwaukee and La Crosse
40—BENSON OPTICAL COMPANY, Minneapolis, Minn. and Eau Claire
44—BEUTLICH, INC., Chicago, Ill.
26—THE BORDEN COMPANY, New York City
121—GEORGE A. BREON COMPANY, New York City
30—BROOK HILL FARMS, INC., Chicago, Ill.
27—BURROUGHS WELLCOME & CO., INC., Tuckahoe, N.Y.

92—CARNATION COMPANY, Los Angeles, Calif.
43—CHICAGO PHARMACAL COMPANY, Chicago, Ill.
70—CIBA PHARMACEUTICAL PRODUCTS, INC., Summit, N.J.

66—DESITIN CHEMICAL COMPANY, Providence, R.I.
122—DICTAPHONE CORPORATION, New York City
36—DIETENE COMPANY, Minneapolis, Minn.

73—EATON LABORATORIES, Norwich, N.Y.
120—ENCYCLOPEDIA AMERICANA, Grand Rapids, Mich.
45—ENCYCLOPEDIA BRITANNICA, Chicago, Ill.
2—ENDO LABORATORIES, INC., Richmond Hill, N.Y.

16—A. J. FARNHAM COMPANY, Milwaukee
22—H. G. FISCHER & CO., Franklin Park, Ill.

59—GEIGY PHARMACEUTICALS, Yonkers, N.Y.
1—GENERAL ELECTRIC CO. (X-Ray DIV.), Milwaukee
28—GERBER PRODUCTS COMPANY, Fremont, Mich.

8—HAUG DRUG COMPANY, Milwaukee
91—HOFFMANN-LA ROCHE, INC., Nutley, N.J.
83 &
84—HURLEY X-RAY COMPANY, Milwaukee

98—INTERNATIONAL LATEX CORP., New York City
20—JOHNSON & JOHNSON, New Brunswick, N. J.
29—KNOLL PHARMACEUTICAL COMPANY, Orange, N.J.
4—KREMERS-URBAN COMPANY, Milwaukee

9—LAKESIDE LABORATORIES, INC., Milwaukee
88 &
89—LANGER LABORATORIES, Milwaukee
74—LA SALLE COCA-COLA BOTTLING COMPANY, Milwaukee
3—LEDERLE LABORATORIES, (DIV. OF AM. CYANAMID CO.), Pearl River, N.Y.
41—ELI LILLY & COMPANY, Indianapolis, Ind.
65—LINCOLN LABORATORIES, Decatur, Ill.
10—J. B. LIPPINCOTT COMPANY, Philadelphia, Pa.
25—LLOYD BROTHERS, INC., Cincinnati, Ohio
117—LOEWI & CO., INC., Milwaukee
82—LOV-E BRASSIERE CO., Hollywood, Calif.

95—MAICO HEARING AIDS, Milwaukee and Madison
85—MARION LABORATORIES, INC., Kansas City, Mo.
35—MARSHALL ERDMAN & ASSOCIATES, Madison
69—S. E. MASSENGILL COMPANY, Bristol, Tenn.
118—MEAD JOHNSON & COMPANY, Evansville, Ind.
51—MEDCO PRODUCTS CO., Tulsa, Okla.
53—MEDICAL PROTECTIVE COMPANY, Ft. Wayne, Ind.
115—MEDICO-MART, INC., Milwaukee
68—MERCK SHARP & DOHME, Westport, Pa.
63—WILLIAM S. MERRELL COMPANY, Cincinnati, Ohio
15—MILEX-ALPHA PRODUCTS, Morton Grove, Ill.
86—MONARCH LIFE, Madison
97—C. V. MOSBY COMPANY, St. Louis, Mo.
55—V. MUELLER & CO., Chicago

14—NATIONAL DRUG CO., Philadelphia, Pa.
119—JOHN NICHOLS, INC., Milwaukee

46—ORTHOPEDIC APPLIANCE CO., INC., Milwaukee
32—ORTHO PHARMACEUTICAL CORPORATION, Raritan, N. J.

99—PARKE, DAVIS & COMPANY, Detroit, Mich.
94—PENGELLY X-RAY CORPORATION, Milwaukee
125—PFIZER LABORATORIES, Brooklyn, N.Y.
37—PHYSICIANS & HOSPITALS SUPPLY COMPANY, Minneapolis, Minn.
13—PLOUGH LABORATORIES, Memphis, Tenn.
6—PROFESSIONAL BUSINESS SERVICE, La Crosse

67—REMICRO SCIENTIFIC INSTRUMENT COMPANY, Milwaukee
116—R. J. REYNOLDS TOBACCO COMPANY, Winston-Salem, N.C.
90—RICHARDS MANUFACTURING COMPANY, Memphis, Tenn.
72—RIKER LABORATORIES, INC., Northridge, Calif.
58—A. H. ROBINS COMPANY, INC., Richmond, Va.
124—ROEMER-KARRER COMPANY, Milwaukee
61—J. B. ROERIG & COMPANY, New York City
71—ROSS LABORATORIES, Columbus, Ohio
96—RYTER CORPORATION, Milwaukee

52—SANBORN COMPANY, Waltham, Mass.
57—SANDOZ PHARMACEUTICALS, Hanover, N.J.
62—W. B. SAUNDERS COMPANY, Philadelphia, Pa.
11—SCHERING CORPORATION, Union, N.J.
12—G. D. SEARLE & COMPANY, Chicago, Ill.
5—SMITH, KLINE & FRENCH LABORATORIES, Philadelphia, Pa.
123—SMITH, MILLER & PATCH, New York City
56—E. R. SQUIBB & SONS, New York City
81—STUART COMPANY, Pasadena, Calif.

23—THERMO-FAX SALES, INC., Milwaukee and Madison

38—ULMER PHARMACAL COMPANY, Minneapolis, Minn.
34—THE UPJOHN COMPANY, Kalamazoo, Mich.
80—U. S. STANDARD PRODUCTS COMPANY, Mt. Prospect, Ill.

7—U. S. VITAMIN & PHARMACEUTICAL CORPORATION, New York City

79—W. T. S. PHARMACEUTICALS (Div., Wallace & Tiernan, Inc.), Rochester, N. Y.
78—WALLACE LABORATORIES, Cranbury, N.J.
24—WARNER CHILCOTT LABORATORIES, Morris Plains, N. Y.
33—WESTWOOD PHARMACEUTICALS, Buffalo, N. Y.
39—WHITE LABORATORIES, Kenilworth, N. J.
54—WINTHROP LABORATORIES, New York City
77—WISCONSIN 7-UP DEVELOPERS ASSN., Milwaukee, Madison and Oshkosh

93—ZIMMER MANUFACTURING COMPANY, Warsaw, Ind.

A Special Annual Meeting Feature

MEDICAL ART SALON

SPONSOR: THE WOMAN'S AUXILIARY TO THE STATE MEDICAL SOCIETY OF WISCONSIN

MILWAUKEE AUDITORIUM . . . MAY 8–10, 1962

Watercolors and Oils Only

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or *his wife* may submit an entry.

LIMITED ENTRIES: Up to 3 pictures per person may be submitted for exhibit.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be in the hands of Doctor and Mrs. William F. Hovis, Jr., Milwaukee, on or before *April 1, 1962. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)*

REQUIREMENTS: (1) All pictures must be framed, with wire and screw eyes attached.

(2) All pictures must be delivered to the Dressing Room on the east side of the Stage of Bruce Hall, Milwaukee Auditorium between 8:00 a.m. and 10:00 a.m., Monday, May 7, and must be picked up in the display area between 3:30 p.m. and 5:00 p.m., Thursday, May 10.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the two categories will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon. Judge: Edward Dwight, Director of the Milwaukee Art Center.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

Notification of Intent to Exhibit

Mail to Doctor and Mrs. Wm. F. Hovis, Jr.—304 E. Bradley Road, Milwaukee 17, Wisconsin, BEFORE APRIL 1, 1962.

I plan to submit a painting, or paintings, for the 1962 MEDICAL ART SALON at the Milwaukee Auditorium, May 7–10.

My entry, or entries, will be:

(1) Watercolor_____ Oil _____ Size _____" wide and _____" deep
(2) Watercolor_____ Oil_____ Size _____" wide and _____" deep
(3) Watercolor_____ Oil_____ Size _____" wide and _____" deep
(1) Title: _____ (2) Title: _____
(3) Title _____

Name: _____

Street: _____

City: _____

RESERVATION FORMS FOR

Roundtable Luncheons • Annual Dinner

NOTE: Attendance Limited! Please List 3 Choices for each of the days you make reservations. List in order of preference. $2.50 per luncheon, including gratuities.

TUESDAY, MAY 8 (See page 205 for listing)

IMPORTANT: Those making reservations for the Marquette and U. of W. Alumni luncheons please make your reservations as indicated and DO NOT INCLUDE WITH THIS RESERVATION.

1. MASTER: THE EMERGENCY TREATMENT OF THE COMPLICATIONS OF CORONARY OCCLUSION
2. REIS: ENDOMETRIOSIS
3. WIED: HORMONAL CYTOLOGY
4. LINDEN: PROBABLE EFFECT OF COMMUNITY AGENCIES ON THE PERSONALITY DEVELOPMENT OF CITIZENS

Nome of Leoder *Nome of Leader*

First Choice: _____ Third Choice: _____

Second Choice: _____

WEDNESDAY, MAY 9 (See page 208 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. OLIVER: PHYSIOLOGICAL EVENTS PRECEDING STEROID–INDUCED DIURESIS IN NEPHROSIS
2. WAISBREN: PRESENT STATUS OF ANTIBIOTIC THERAPY
3. HUMPHRIES: ROLE OF EMBOLI IN PRODUCING LIMB ISCHEMIA
4. BERNHARD, MILLER & WELSH: REHABILITATION IN ARTHRITIS
5. MEYER: NEWER DRUGS AND THEIR USES
6. NOVAK: DYSMENORRHEA
7. McCRUMB: MEASLES AND MEASLES PROPHYLAXIS (Including Measles Encepholitis)

Name of Leoder *Name of Leoder*

First Choice: _____ Third Choice: _____

Second Choice: _____

THURSDAY, MAY 10 (See page 211 for listing)

LIST *THREE CHOICES* IN ORDER OF PREFERENCE

1. McVAY: CHOLANGITIS
2. EVANS: NEWER ROENTGEN METHODS IN EXAMINATION OF KIDNEY
3. GOLDMAN: SOME CONSIDERATIONS OF METHODS FOR INCREASING THE EFFECTIVENESS OF TOPICAL CORTICOSTEROID PREPARATIONS
4. ROSTENBERG: PATCH TESTING: INDICATIONS AND TECHNIQUES
5. SEVERINGHAUS: THE ANESTHESIOLOGIST AS RESPIRATORY CONSULTANT
6. BECKMAN: THE THEOPHYLLINE DRUGS
7. MATTINGLY: INFERTILITY: ETIOLOGICAL FACTORS AND MANAGEMENT

Name of Leoder *Nome of Leoder*

First Choice: _____ Third Choice: _____

Second Choice: _____

ANNUAL DINNER, Wed., May 9

DANCING
SHORT SPEECHES—COCKTAILS **$7.00** PER PERSON
(Including Gratuities)

Number Luncheon Tickets ($2.50 each) . . . . . for $_____

Number Annual Dinner Tickets ($7.00 each) . . _____ for $_____ TOTAL $_____

Moke Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ STREET _____ CITY _____

(Print, pleose)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin

the Wisconsin Medical Journal

APRIL 1962

VOLUME 61

NUMBER 4

ROBERT S. BALDWIN, M.D.

AFTER A FULL dozen years of service as Medical Editor of this Journal, Dr. Robert S. Baldwin of Marshfield is leaving his editorship. At his own request, the Council of the State Medical Society relieved him of his position in February and appointed Dr. Victor S. Falk of Edgerton in his place.

Good journals—and we believe we can include the *Wisconsin Medical Journal*—have a distinctive personality that makes them acceptable to some readers, detested by others. Editorial style, format, content, integrity, typographical excellence and printing quality all contribute to the establishment of that personality. In the roster of state medical magazines, the *Wisconsin Medical Journal* holds an enviable position, not only for its general superiority, we are proud to say, but also, and particularly, for the high caliber of its scientific articles. More than any other single person, Doctor Baldwin is responsible for our fine reputation in this area.

Members of the staff of the *Wisconsin Medical Journal* know how many hours Doctor Baldwin has devoted to the careful, kindly editing of scientific articles submitted to the Journal. His conscientious attention to detail and his skilled redaction have made authors out of some doctors whose techniques of communication have not kept pace with their scientific prowess. Fortunately for the Journal, Doctor Baldwin is a man of letters as well as a distinguished internist, and through his services, our reputation for scientific superiority has flourished as our literary characteristics have been maintained at a consistently high level.

For the personality of a scientific magazine it is a matter of no small import that the spurious be excluded. Doctor Baldwin's vigilance has kept the Journal free of "planted" material to establish a published

reference for a new drug, or for other non-scientific purposes. Readers of this Journal could be sure of the integrity of articles appearing in our pages—in accordance with the policy of the State Medical Society and the Editorial Board.

While his active contribution to this magazine will be missed, Doctor Baldwin will not leave the scene entirely. As consulting editor, his presence will inspire his successor and his counsel will be available to all.

Congratulations and thanks, Doctor Baldwin, for your superb service to your colleagues and to your profession.

Congratulations and good luck, Doctor Falk, on your appointment to succeed a shining exemplar of medical journalism.

—D. N. G.

Fluorescent Antibody Methods in the Diagnosis of Disease

By STANLEY L. INHORN, M.D.

Madison, Wisconsin

SINCE 1955, a quiet but nevertheless major revolution has taken place in the field of medical microbiology. This great advance is the application of fluorescent antibody (F.A.) techniques to the diagnosis of infectious diseases. The revolution was sponsored to a large extent by the U. S. Public Health Service, through its Communicable Disease Center in Atlanta, Georgia, and through research grants to universities and to medical and public health laboratories. In a short period of time, this radically different approach to laboratory diagnosis has gained widespread publicity, as hundreds of new clinical laboratory applications have been introduced. Many commercial supply companies now offer a complete line of F. A. reagents and equipment, so that the methods are available to even the smaller hospital laboratories.

Although the basic principles of the F. A. techniques are straightforward, there are many problems in methodology that necessarily delay immediate acceptance of any new application. Essentially the technique involves the tagging of antisera with fluorescent dyes and then employing these labeled antisera to visualize organisms in tissues or on smears. When a new F. A. test is developed, the question naturally arises as to the specificity of the labeled antisera. To put it more simply, one must ask whether the particles seen through the microscope are really the organism in question. On the opposite side of the coin, one must consider whether the method is sensitive enough to identify organisms if, for example, they are present in small numbers. These questions of specificity and sensitivity are not peculiar to the F.A. method, but must ultimately be satisfied for any new clinical laboratory procedure. At present many F. A. tests are being carefully compared to existing "classical" microbiological methods, with the recognition that many of the latter are far from perfect but merely serve as convenient references.

What then is behind the "big push" for F. A. methods? Primarily, F. A. tests have an extremely important advantage in rapid identification of microorganisms, permitting a diagnosis in hours instead of days or weeks. In addition, most F. A. tests are proving to be extremely sensitive, so that relatively few organisms may be identified even in the presence of numerous contaminants. Also most F. A. tests have been found to correlate well with routine methods. Finally F. A. tests have the added advantage that they do not require living organisms, thus minimizing

(Continued on page 228)

Doctor Inhorn is Pathologist and Assistant Director, State Laboratory of Hygiene, Madison.

Ragweed Pollen Counts and Their Correlation with Symptoms

By WILLIAM H. LIPMAN, M. D., F.A.A.A. and MR. FRANK I. VILEN

Kenosha, Wisconsin

THE PURPOSE of this paper is threefold: (1) To report a four year field survey of seasonal ragweed pollen counts within a medium-sized community (Kenosha) in southeastern Wisconsin, a known high ragweed incidence area. (2) The relation and correlation of the reported ragweed pollen counts to the symptoms of a control group of patients. (3) The meteorological factors influencing aerial and local dispersion of ragweed pollen granules.

METHODS AND PROCEDURES

Two widely separated locations were selected as sampling stations: (1) Station No. 1 was on the roof of the United States bank building at elevation 149.21 city datum.* This is the tallest building in the city, located almost exactly in the east central part of the city and at least 300 feet above any other building structure; and it is within the commercial area, at least 1,000 yards from any source of ragweed growth. (2) Station No. 2 was on the roof of the sewage treatment plant building located in the most southeasterly section of the city (in an area of dense ragweed growth). Its elevation is 38.05 city datum.

The difference in elevation between these stations is 111.16 feet. At each sampling station, a standard gravity sampler was placed with the counting chamber plane horizontal to the ground. Vaseline-coated slides were collected from these samples daily (except Sundays) from August 1 through September.

Meteorological data was secured from the local weather bureau station. Correlating this data with each pollen catch per sampler would add some information relative to the local dispersion of the pollen. Such elements as wind direction and velocity, turbulence, temperature and humidity are known factors in determining pollen distribution.

We were able to plot the daily pollen counts taken at the two stations against the meteorological backgrounds of wind velocity and wind direction, relative humidity, and precipitation for each of the four ragweed pollen seasons, 1956 through 1959. These results are illustrated in Figures 1–4.

Figure 1 charts the daily ragweed pollen counts of only station No. 1, the high level station, from August 15 to August 27. We were unable to begin ragweed pollen counts at station No. 2, the low level station, until August 27, 1956, because of technical difficulties and arrangements.

However, the highest ragweed count of station No. 1 did not go much over 200 granules per cubic yard of air until August 22, 1956, when it reached 220, and that day there was a strong west wind of 12 miles per hour.

From August 27, 1956 onward, there was a marked diversity of ragweed pollen counts between the high level station (No. 1) and the low level station (No. 2). On August 27, 1956, for instance, the ragweed pollen count at station No. 1 was around 100 granules while at station No. 2, it reached 1,360. Between August 30, 1956 and September 3, 1956, the counts varied from 90 to 175 at station No. 1 versus counts of 900 to 1,260 at station No. 2. During these days, the wind direction was mainly from the south and west, the wind velocity between 5 to 10 miles per hour, and the humidity range from 60 to 80 per cent, with sunny skies. This pattern was rather consistent throughout the remainder of the 1956 ragweed season.

Presented at the Fourth International Congress of Allergology, New York, October 15–20, 1961.

*City datum is an arbitrary plane to which all local elevations are referred and is 577.42 feet above mean sea level.

Mr. Vilen is superintendent of the sewage treatment plant and sanitary engineer of the City of Kenosha.

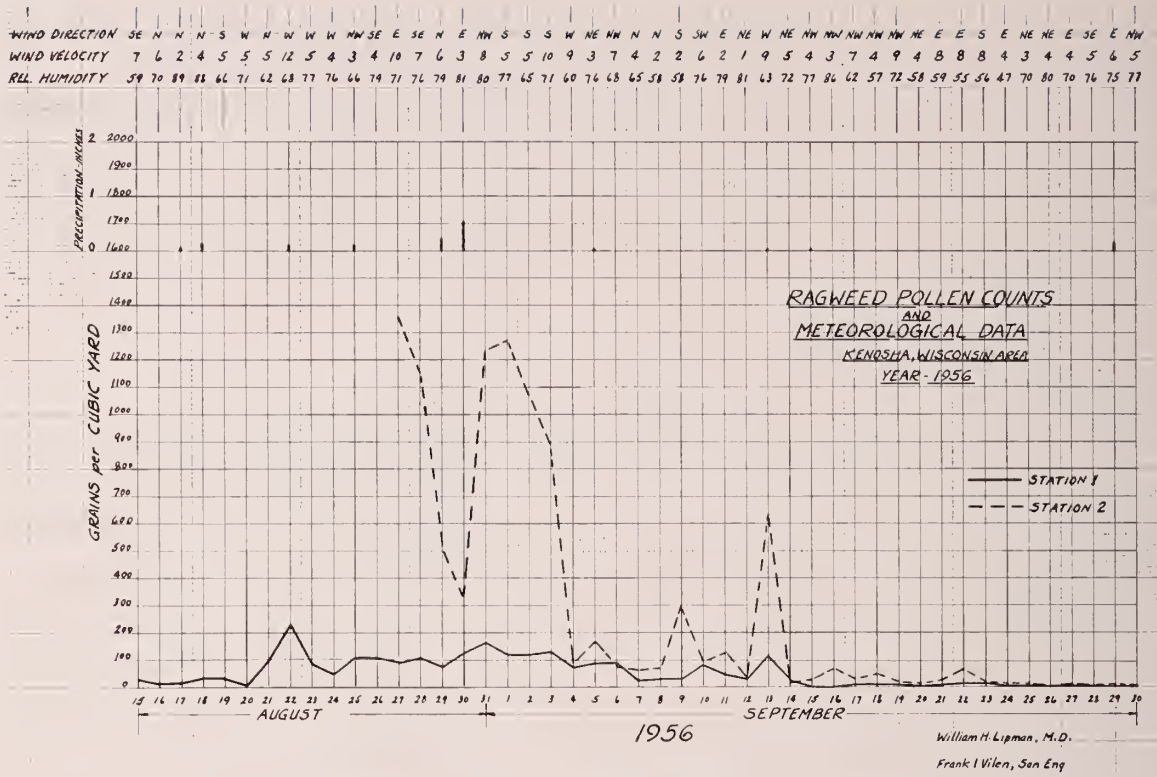


Fig. 1—Daily pollen counts token at two stotions during the 1956 ragweed pollen seoson.

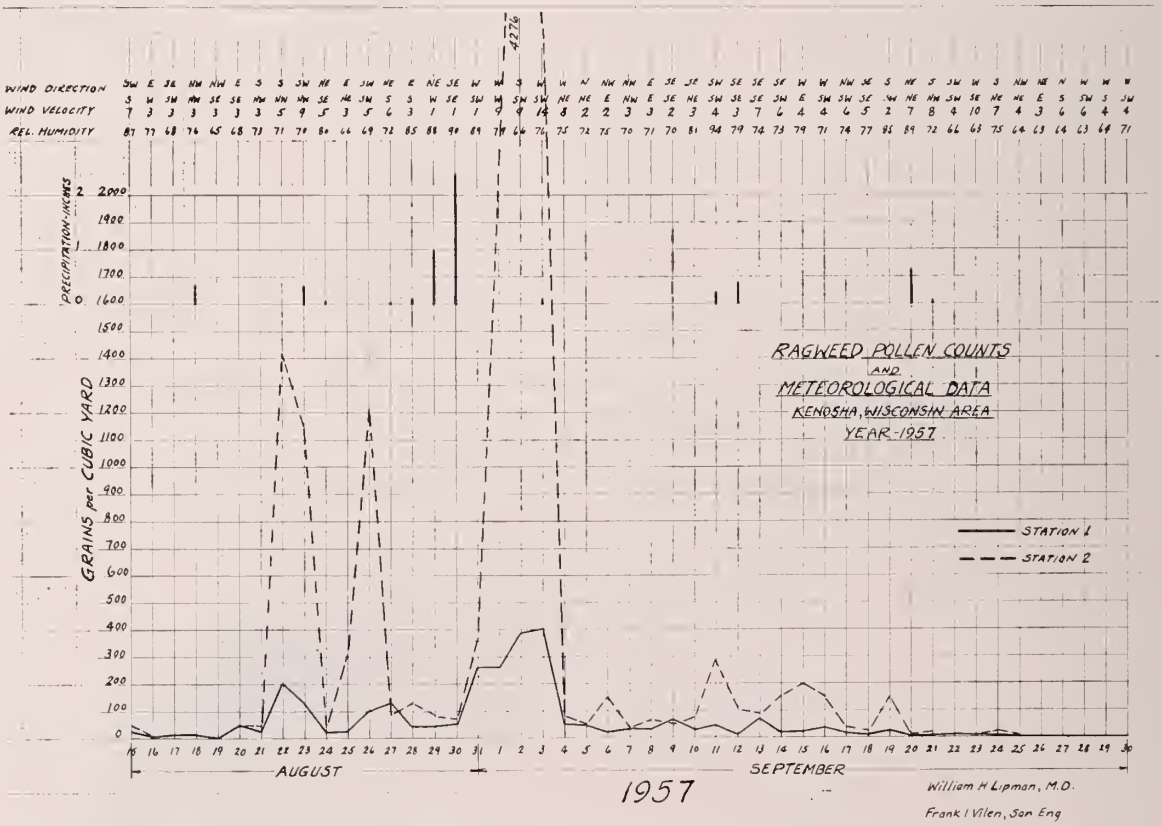


Fig. 2—Daily pollen counts taken at two stations during the 1957 ragweed pollen season.

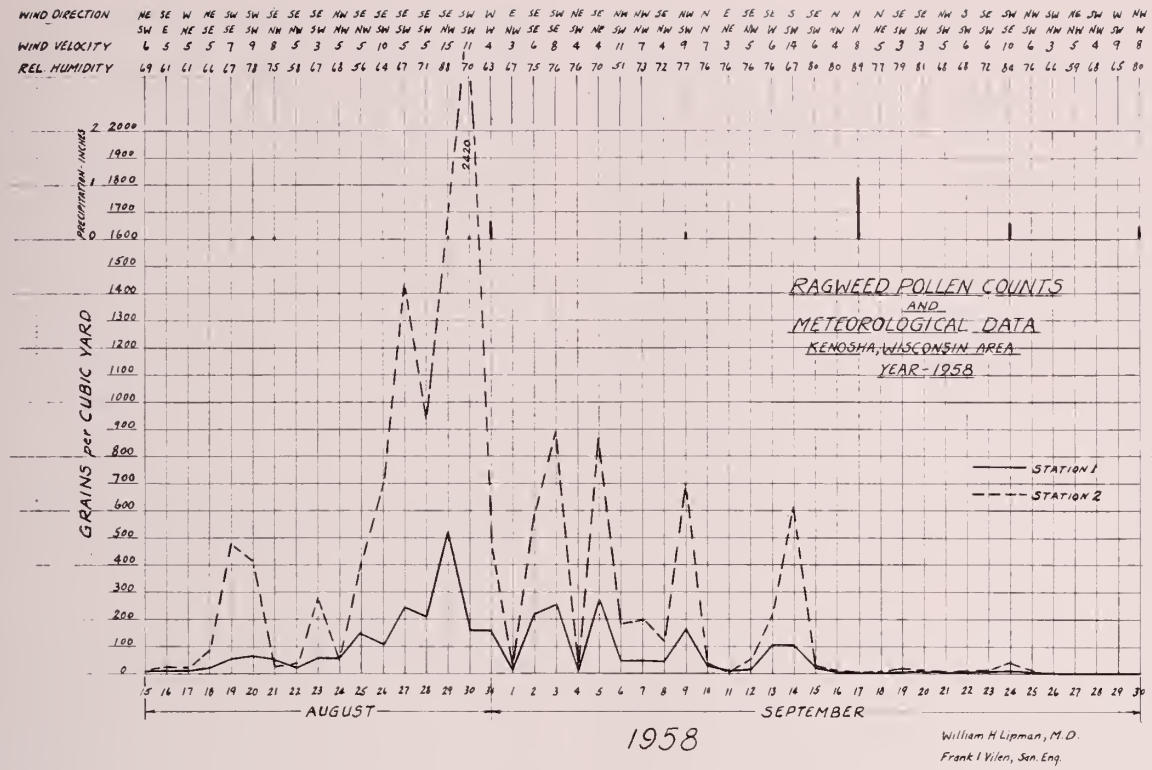


Fig. 3—Daily pallen caunts taken at twa statians during the 1958 ragweed pollen season.

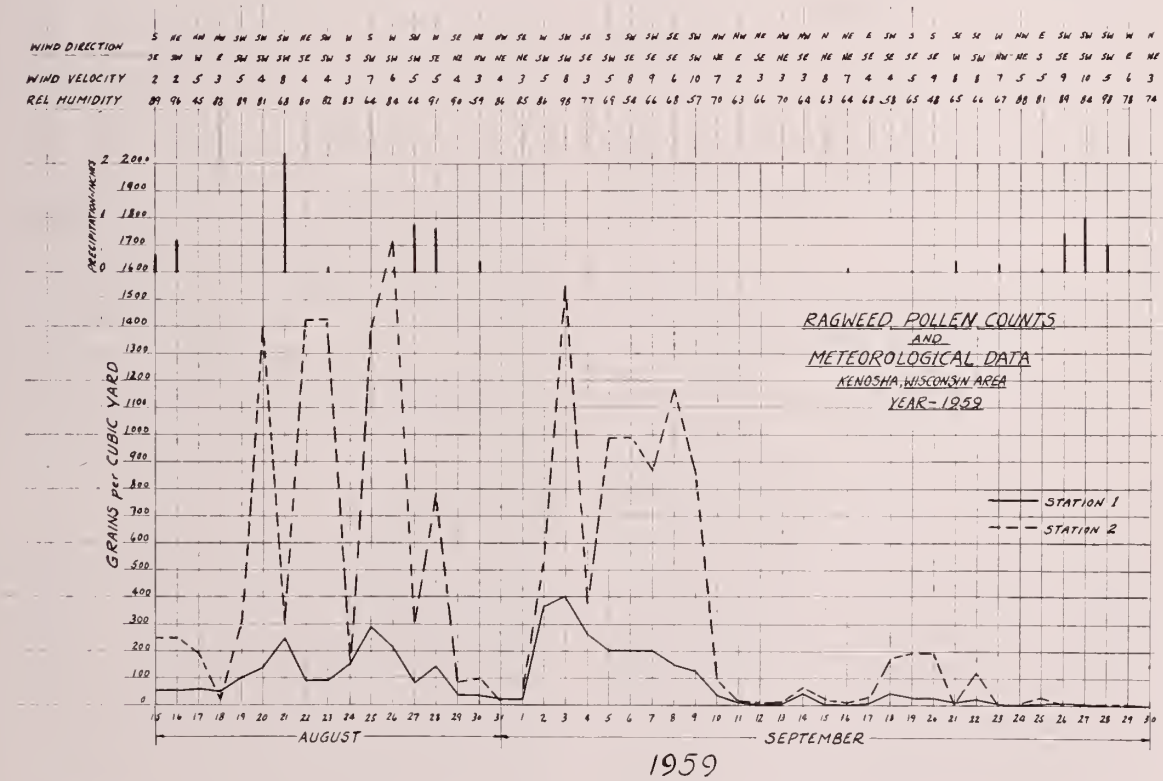


Fig. 4—Daily pallen counts taken at twa statians during the 1959 ragweed pollen season.

The 1957 through 1959 ragweed pollen seasons (Fig. 2, 3 and 4) showed similarly consistent patterns—the ragweed pollen counts at low station No. 2 exceeding those of high station No. 1 by five to ten times. For instance, the peaks in 1957 were 200 on August 22, 1957, at station No. 1 compared to 1,400 at station No. 2; 130 versus 1,200 on August 26, 1957; 275 to 400 (station No. 1) versus 4,200 plus (station No. 2) August 31, 1957, to September 4, 1957; with a similar declining pattern for the 1957 season. In 1958 and 1959, the above patterns repeated themselves.

We believe that there are two main reasons for the consistent diversity of these ragweed pollen counts. First, as stated previously, station No. 1 is over 111 feet higher than station No. 2. Second, it is over one and a half to two miles from any dense ragweed growth. Station No. 2 is surrounded on three sides by ragweed within an area of several hundred yards. It would appear from this data that the great variance of pollen counts within each area and within each community of that area is due to such factors as: (1) site of the station, i.e., its height and proximity to the source of pollen, and (2) certain meteorological conditions, which will be reported briefly. A considerable amount of misunderstanding in the minds of the medical profession, and the public as well, results from this variance in published pollen counts within certain geographical locations. Meteorological factors vary from area to area, particularly in heavily populated areas with tall buildings where troughs and wind downdrafts increase the pollen density at ground levels.

We tried to correlate our pollen counts with the symptoms of ragweed pollenosis. In order to do this, we selected a group of 20 patients (five each year) with severe ragweed symptoms. They were previously untreated (allergically or symptomatically) and presented themselves early in the season because they thought they had colds or knew they had hay fever. All were intelligent, literate persons, 16 to 58 years of age. There were 9 females and 11 males. Each was given a questionnaire listing main symptoms for each year and advised to return at least once a week for a checkup and interview. They were given enough medication for approximately one week. Patients with moderate to severe symptoms were treated symptomatically with antihistaminics and/or steroids

QUESTIONNAIRE

Name of Patient . . . . . .

Dates			Symptoms					Treatment Required
Mo.	Day	Year	Sneezing or Dripping	Nasal Blocking	Itching or Tearing	Cough	Wheezing	
Aug. 15								
thru								
Sept. 30								

Code: 0—No symptoms
1+—Mild
2+—Moderate
3+—Severe

and asked to note on their questionnaires the exact amount of medicine required each day to control symptoms. An attempt was made to correlate the symptoms of each group to the daily pollen counts.

The antihistaminics of our choice were parabromdylamine maleate (Dimetane), 4 mg. one to four times daily; or parabromdylamine (brompheniramine) maleate (Dimetane Extentabs), 12 mg. one to two times a day. In our experience, there was less drowsiness with these drugs while obtaining as good or better antihistaminic effects than with most antihistamines. For more distressing symptoms, we prescribed the steroids, dexamethasone (Deronil), 0.75 mg., one to four times a day as needed, or dexamethasone (Decadron), 0.75 mg., one to four times a day for no longer than one week to ten days at a time. In a few instances triamcinolone (Aristocort), 4 mg., one to four times daily, or as needed, was used. Another effective antihistaminic, antiasthmatic compound was ethylnorepinephrine hydrochloride (Bronkotabs). The addition of the glyceril compound enhanced its effectiveness as an expectorant. There were no cases of intolerance to the antihistamines, but we had to change the steroids from time to time on some of the patients.

DISCUSSION

With every patient, to a relative degree, the severity of the symptoms ran somewhat parallel to the height of the ragweed counts —with the symptoms of each patient reaching his or her greatest index of discomfort at the peaks of the ragweed pollen counts. In most cases, the symptoms were ameliorated and controlled by the antihistamines and/or the steroids.

Of the 20 patients, 16 developed a cough and in some instances, wheezing, during the termination of the regular ragweed pollen season when other upper respiratory symptoms had subsided or diminished. This might be explained by the prolonged trauma and irritation to which the entire respiratory tree had been exposed during the regular pollen season. In addition, temperature changes and residual pollen present in the home are contributing factors which trigger symptoms in the already sensitized mucous membranes into spasms.

Meteorological Factors

The importance of the meteorological factors—wind direction, velocity, and air turbulence, temperature and humidity— in determining pollen distribution appears to be confirmed to a considerable degree by our findings. Previously, Shapiro and Rooks, Crawford, Durham, and others, noted these factors: that wind velocity determines (in part at least) the dispersion of ragweed pollen from the plant and affects the amount of pollen collected by the standard growth sampler. Crawford also found that the minimum velocity of dry air required to maintain pollen grains in airborne condition was 1.58 cm. per second, and that, disregarding air turbulence, a horizontal flow of air at 1.58 cm. per second could overcome the force of gravity and thus produce airborne pollen. While a horizontal air velocity of only 1.86 feet (.035 miles per hour) is sufficient to maintain much of the pollen liberated into the air from the local source, such a velocity may not necessarily be sufficient to pick up appreciable amounts of pollen granules after they have settled upon the ground, vegetation, or other objects. Air turbulence usually accompanies a horizontal air stream, and since the earth is unequally heated by the sun, upward and downward connection currents of air between ground areas produce different degrees of temperature. Various obstructions on the ground—trees, buildings, even pollen plants themselves—could create additional turbulence. Therefore, air velocity with its wind currents can be responsible for gravity catch. Many investigators note that the severity of symptoms in patients correlates roughly with reported pollen counts in given local areas.

Wind Direction

This element would be important as a factor in pollen counts in our own area inasmuch as this community is located on the southwestern shores of Lake Michigan. Cooling winds from the east or northeast, sweeping over Lake Michigan, would be expected to carry a smaller yield of pollen granules since some may be lost by dispersion over the lake itself. Winds from the west, southwest, south, and southeast, on the other hand, are not tempered by the waters of Lake Michigan; and hence, would be expected to bring increased loads of pollen from the ragweed-producing regions of the plains. On windy days there could be larger numbers impinged upon the conjunctiva just as there are upon vaselined slides because of the larger volume of air striking the conjunctiva.

Sunshine and Humidity

With increased sunshine there is increased pollen production. Also, Markow and Spain have shown that with increased humidity there is actually a decrease in pollen fallout. Under natural conditions, with a low wind velocity during the night and with less air turbulence than would be present during the day, and with an increase in the humidity, one should expect a rapid fall in the atmospheric ragweed pollen.

Limitations of such mechanical and electrical devices as air-filtering units, vacuum cleaners, air purifiers, and the like, in completely removing ragweed pollen from homes in which it has time to settle, are obvious. Often pollen granules settle on such items as furniture, drapes, and bedspreads where it cannot be reached by these devices. As previously stated, this may also account to some degree for the postseasonal persistence of ragweed symptoms.

SUMMARY

Ragweed counts taken at two different stations have shown markedly diverse patterns. The low level station near ragweed growth shows a definitely increased count. Location of the counting station and meteorological factors influence ragweed pollen count patterns. Symptoms parallel to a considerable degree the fluctations in pollen counts—with variations among individual patients. Antihistaminics and steroids can ameliorate and alleviate the pollen symptoms complex in pre-

viously untreated persons. The postseasonal syndrome was present in a large percentage of patients (who did not have previous allergic management).

625–57th Street.

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FLUORESCENT ANTIBODY METHODS IN THE DIAGNOSIS OF DISEASE

continued from page 222

the problem of false negative reports due to loss in transit of fastidious organisms. Because of these decided improvements, F. A. methods are now being applied to many problems in diagnostic bacteriology, parasitology, serology, and mycology.

Currently, several fluorescent methods are being evaluated at the Wisconsin State Laboratory of Hygiene. A Rheumatic Fever Prevention Unit was established in 1960 with funds from the Wisconsin Heart Association and the Heart Control Branch, U.S.P.H.S. This program is being carried out in cooperation with these agencies and with the State Medical Society and State Board of Health. It provides rapid F. A. identification and reporting within 24 hours of Group A beta hemolytic streptococci. In a one-year period, November 1, 1960, to October 31, 1961, almost 19,000 throat swabs were submitted, 19.8% of these were positive for beta hemolytic streptococci of which 81.3% were identified as Group A. On the first 2,500 specimens, with the precipitin test as the standard of comparison, the F. A. test was 95.2% sensitive and 86.1% specific, with good overall agreement of 89.8%.

Other tests currently being evaluated include a fluorescent treponemel antibody test, using intact Treponema pallidum (Nichols strain). Experience here and at other laboratories suggest that because of its ease and specificity, the F. T. A. test may replace the awkward Treponema Pallidum Immobilization test. Recently E. A. Edwards, immunologist at the State Laboratory of Hygiene, has devised a method for detecting T. pallidum in primary chancres using the F. A. technique. In general, the results of fluorescent identification were superior to darkfield results because of easier discernability and more rapid identification of spirochetes.

F. A. methods for identifying the Eaton agent of primary atypical pneumonia, pathogenic E. coli, and Negri bodies of rabies have shown certain distinct advantages. A fluorescent lupus erythematosus test has many time-saving features. This growing list of applications certainly suggests a major revolution in the laboratory. It is not too far-fetched to contemplate that the hygiene laboratory of the future may consist of a darkroom, an ultraviolet light source, a microscope, and fluorescein-labeled antisera.

Hereditary Hemorrhagic Telangiectasia

Rendu-Osler-Weber's Disease

By DUANE L. LARSON, M. D., JOHN T. MENDENHALL, M. D., and ERWIN R. SCHMIDT, M. D.
Madison, Wisconsin

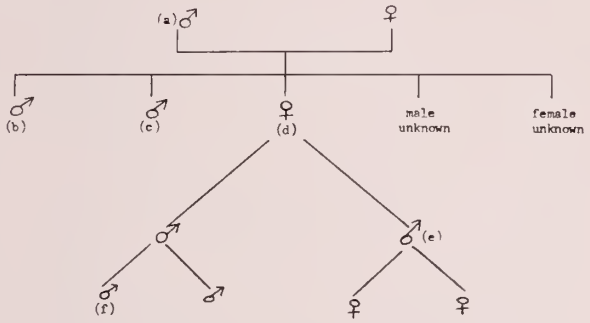
HEREDITY hemorrhagic telangiectasia is a vascular disease characterized by localized dilatation of arterioles, venules, and capillaries into angiomata. Clinically these telangiectasia are seen to give rise to recurrent bleeding, which may be spontaneous or follow slight trauma. Hemorrhagic phenomena are frequently seen in clinical medicine, and this disease should be considered in the differential diagnosis of abnormal bleeding.

The following case reports indicate some of the problems associated with this disease.

CASE REPORTS

Case 1: Mr. M. S., a 69-year-old grocer, was hospitalized on Feb. 11, 1960, with the multiple complaints of recurrent melena, epistaxis and dyspnea. He said his first epistaxis occurred at the age of 18 years. A few years later he began to bleed from the mucous membranes of the palate and lower lip. In 1940 a biopsy was taken from the palate and lower lip; the diagnosis was telangiectasia. He was hospitalized in 1950 for hematuria, at which time a urological examination was negative. On Nov. 12, 1959, he was admitted to his local hospital with the complaints of dyspnea, orthopnea, and intermittent melena. Pulmonary function studies indicated that an arteriovenous shunt might be present.

On Dec. 22, 1960, he developed acute dyspnea and cyanosis which caused him to become semi-comatose. The spinal tap revealed xanthochromic fluid containing numerous red blood cells. He gradually recovered from this and was referred to the Veterans Administration Hospital on Feb. 11, 1960.



The patient's family history was interesting and is as follows:

(a) His father had frequent epistaxis.
(b) The patient.
(c) A brother had frequent epistaxis, retinal hemorrhages, and scattered angiomata.
(d) A sister had severe secondary anemia during her life from excessive menstrual flow. Following hysterectomy, the anemia continued despite numerous therapeutic regimens; e.g., snake venom, rutin, and vitamin C. She died at the age of 61 years with a cerebral vascular accident.
(e) A nephew with typical scattered angiomata, also had frequent epistaxis, melena and hematuria.
(f) A history given of frequent epistaxis.

On physical examination, he was found to have a number of small, bluish red, punctate, slightly raised angiomata distributed over the face, ears, nasal mucosa, hard palate, lips, conjunctiva, tongue, pads of the fingers, under the fingernails, arms, and thorax. The remainder of the physical examination was unremarkable. Hematologic examination was within normal limits.

During hospitalization pulmonary insufficiency improved and the melena cleared spontaneously.

From the Department of Surgery, University of Wisconsin Medical School, Madison, Wisconsin.

Doctor Larson's present location is the University of Texas Medical Branch, Galveston, Texas.

Doctor Schmidt succumbed July 9, 1961, after submission of this paper.

Case 2: Mr. F. C., 56-year-old white man, was admitted to the hospital on Dec. 2, 1956, complaining of intermittent melena of two years duration. He had been hospitalized elsewhere on four different occasions in the two years prior to admission for blood transfusion.

Family and past medical history were unremarkable, and on physical examination no significant abnormality was found.

On admission the hemoglobin level was 9.5 gm. per 100 ml. and the hematocrit reading was 30%. Chest x-ray films, barium enema, and an upper gastrointestinal series were negative, as was the hematologic examination.

Because of the continuous gastrointestinal bleeding an exploratory laparotomy was performed on Nov. 28, 1956. No abnormality was found, except for the presence of numerous small, red, vascular-like lesions measuring 2 to 8 mm. scattered throughout the small intestine, especially involving the jejunum. A biopsy of the lesions revealed telangiectasia on microscopic examination. No active bleeding areas were observed; therefore, the abdomen was closed. Postoperatively the patient continued to have melena which gradually ceased over a period of two weeks.

In the following four years, since 1956, the patient received 200 blood transfusions for intermittent melena.

Case 3: Mr. R. R., a 64-year-old white farmer, was admitted to the hospital on May 3, 1960, with a five-year history of vague abdominal complaints and intermittent melena.

The family and past medical history were unremarkable.

A cholecystogram revealed multiple cholelithiasis. An upper gastrointestinal series indicated a deformity of the duodenal bulb, and barium enema revealed diverticula in the descending colon. Hematologic studies were all within normal limits.

On June 28, 1960, an exploratory laparotomy revealed minimal scarring of the duodenum, but no ulceration. The liver contained multiple small nodules, measuring approximately 5 mm. in diameter, deep within its substance. The small intestine contained multiple areas of telangiectasia, especially in the jejunum. On further exploration splenomegaly, cholelithiasis, and a Meckel's diverticulum were also found.

The postoperative course was uneventful and the melena ceased spontaneously.

Case 4: Mrs. M. T., a 51-year-old housewife, died at the hospital, from widespread metastatic carcinoma. The primary site was the left breast which had been resected 18 months previously.

An incidental finding at autopsy was the presence of numerous telangiectasia of the small intestine, especially the jejunum. A few lesions were also seen in the colon.

Case 5: Mrs. C. P., a 49-year-old housewife, was admitted to the hospital on Mar. 13, 1961, with a long history of anemia. In May of 1951 she was first noted to be anemic with a hemoglobin level of 10 gm. per 100 ml. In the spring of 1955 she began to develop signs and symptoms of cardiac decompensation. The decompensation was fairly well controlled up to this admission with vigorous medical therapy. Cardiac catheterization in May, 1958, revealed a high output type of failure, with no evidence of congenital heart disease.

Family history was noncontributory. However, the past medical history revealed a history of epistaxis as a child and menorrhagia as an adult.

On physical examination she was noted to have telangiectasia located on the face, nares, lips, tongue and trunk. Vaginal examination revealed telangiectasia of the vaginal mucosa. Signs of chronic cardiac decompensation were present as pedal edema, hepatomegaly, splenomegaly, cardiomegaly and increased venous distention. An epigastric thrill was noted over the left lobe of the liver, as well as a to and fro loud murmur. This appeared to be a large arteriovenous fistula.

On this admission she also gave a six-month history of progressive abdominal enlargement. On physical examination a large suprapubic mass arising to the umbilicus was noted. It was believed this was most likely an ovarian neoplasm and an exploratory laparotomy was indicated. At surgery, a large malignant ovarian lesion was found. She also had telangiectasia of the small intestine, especially the jejunum and what appeared to be an arteriovenous fistula in the liver.

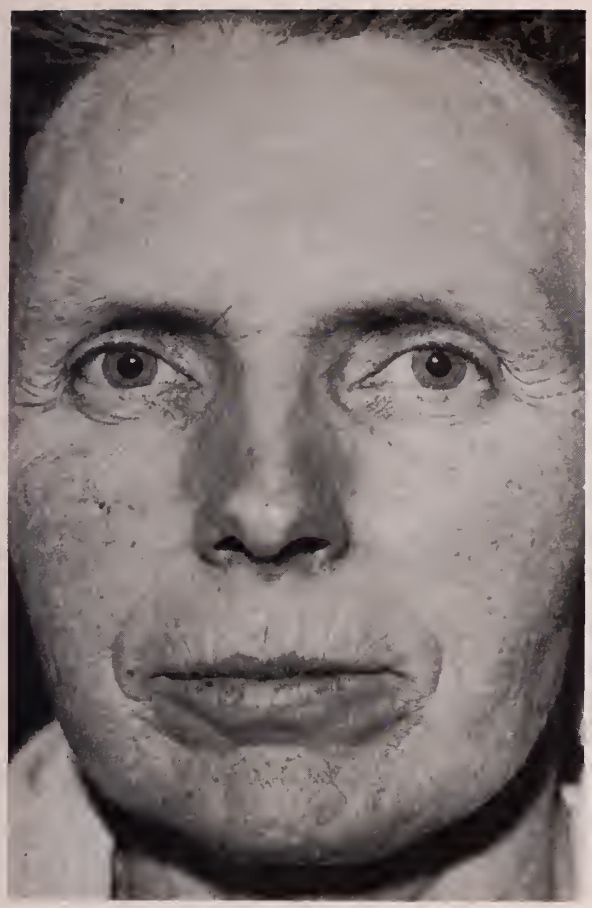


Fig. 1—Examples of all three varieties of telangiectasis: pinpoint lesions, spider angiomas, and the nodular variety.

Fig. 2—Nodular telangiectasis of the tongue.

HISTORY

Rendu,[1] in 1896, described a 52-year-old man who had epistaxis for 40 years together with telangiectasia of the skin of the trunk, face, and mucous membrane of the mouth. The patient's mother and brother also had epistaxis and his father had melena. Rendu thought this clinical picture was a type of pseudohemophilia. This disease was recognized as a clinical entity when Sir William Osler,[2, 3] in 1901, reviewed a number of families with the disease and described the lesion and clinical features. Weber,[4] in 1907, made further contributions, especially in pointing out the frequent occurrence of epistaxis prior to the development of telangiectasia, Hanes,[5] in 1909, described the histopathology and suggested the descriptive terminology of hereditary hemorrhagic telangiectasia, which indicates the diagnostic triad of (1) familial history, (2) repeated hemorrhages, and (3) multiple telangiectasia.

INCIDENCE AND HEREDITARY ASPECTS

Rendu-Osler-Weber's disease is not a rare disease. Garland,[6] in 1950, reviewed the literature and found 1,415 cases, 648 males and 703 females.

The disease is transmissable by both sexes as a Mendelian dominant and may be associated with other inherited abnormalities.[7] Approximately 20 to 40 per cent of close relatives of a known case of hereditary hemorrhagic telangiectasia are found to have evidence of it. Wintrobe[8] reported a Mormon with Rendu-Osler-Weber's disease who had 22 children by four wives. Ten of these were affected.

Occasionally an involvement of a particular organ system may be passed down through each generation. Baker[9] described a family with a history of hereditary hemorrhagic telangiectasia in five members of four generations who had hematemesis and melena. Heyde[10] reported this disease in a mother and son who had pulmonary arteriovenous fistula.

Fig. 3—Telangiectasis of the hard palate.

ETIOLOGY, PATHOLOGY AND CLASSIFICATION

The etiology is not known. Many believe that this condition is due to defective capillary contractility, probably secondary to congenital anomalies of the capillaries and venules. Whitby and Britton[7] classify this hemorrhagic condition as follows:

Hemorrhagic Conditions Due to Defective Capillary Contractility

(a) Hereditary hemorrhagic telangiectasia (Rendu-Osler-Weber's disease).

(b) Ehlers-Danlos syndrome. This syndrome includes abnormal elasticity and fragility of the skin and fragility of the blood vessels.

(c) Von Willebrand's disease (hereditary pseudohemophilia). This is a hereditary bleeding dyscrasia appearing in males and females characterized by a tendency to bleed profusely. There is a prolonged bleeding time, a normal coagulation time, and efficient clot retraction with no reduction in platelets.

Histologically, the involved vessels have a thin wall consisting mainly of endothelium. They appear as capillary angiomas and cavernously dilated varices with a loss of rete pegs of the overlying epithelium.[11]

CLINICAL COURSE

The characteristic feature of this disease is recurrent hemorrhage from the telangiectatic areas. The usual history is that of repeated epistaxis first noticed during childhood, with telangiectatic areas frequently occurring about the third or fourth decade.

The telangiectatic lesions are well demarcated, bright red or violaceous and partially blanch on pressure. They are of three varieties: (1) the pinpoint lesions which are most commonly seen on the hands and face and are relatively inconspicuous, (2) the spider angiomas which are similar to those observed in some cases of cirrhosis of the liver, and (3) the nodular variety which are approximately 3 to 4 mm. in diameter and raise above the level of the skin. These may originate in the center of a spider angioma.[12]

It is not unusual for a patient to be in the fifth or sixth decade before he is aware of his disease.

Usually there is a family history of recurrent bleeding; however, Figi and Watkins[13] reported six cases in which no family history of bleeding was noted.

Telangiectasia can occur in many areas and result in epistaxis, hematuria, menorrhagia, hemoptysis, hematemesis or melena. Fox[12] reported an excellent review of this.

1. Skin—skin lesions may be distributed as follows:[14] face 70%, lips 65%, nares 65%, ears 35%, hands 35%, chest 15%, feet 15%. (See Figs. 1, 2 and 3)
2. Mucous membranes—nose: the telangiectasia are found in Kiesselbach's triangle; mouth: lips, gum, tongue and hard palate.[15]
3. Lungs—hemothorax, hemoptysis, polycythemia, hypoxemia, cyanosis and clubbing may occur.[16]
4. Gastrointestinal (See Figs. 4, 5 and 6) —gastrointestinal hemorrhage, as the sole presenting symptom or sign of the disease, is common.[12] Telangiectasia have been found from the oropharynx to the anus.[17, 18] Hardt and Stegman[19] reported six cases of gastrointestinal bleeding. In one there was no other evidence of the disease, nor was there a positive family history.
5. Liver and spleen—hepatosplenomegaly has been noticed in a number of patients with this disease. Smith and Luebach[20] reported the possible explanation as a typical postnecrotic cirrhosis secondary to post-transfusion hepatitis, or telangiectasia of the liver, or congestive heart failure secondary to the chronic anemia.
6. Urogenital—bone and central nervous system involvement have been reported but uncommon.

DIAGNOSIS

The diagnosis can usually be made if this disease is considered and the four main diagnostic points are looked for; i.e., (1) positive family history, (2) visible telangiectasia, (3) tendency to bleed from these areas, and (4) usually normal bleeding and coagulation studies. The telangiectasia may be spiderlike; however, these can frequently be differentiated from the telangiectasia of liver disease. The typical arterial spider of liver disease is fiery red in color and pulsatile; it infrequently involves the mucous membrane, blanches readily on pressure, and is not commonly seen below the umbilicus. The lesions of Rendu-Osler-Weber's disease are usually purplish, red, nonpulsatile and frequently involve the mucous membranes. They are difficult to blanch and are seen frequently below the umbilicus.

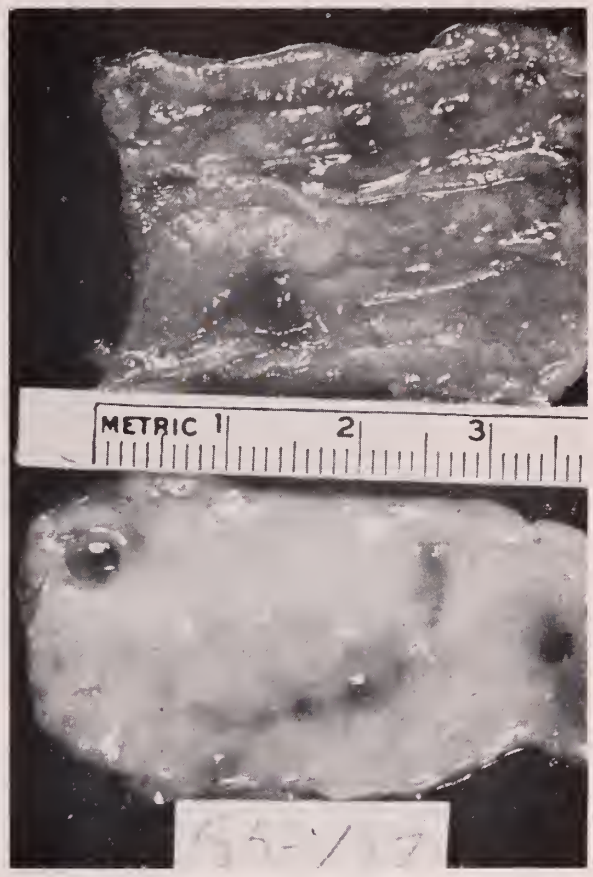


Fig. 4—Telangiectasia involving the mucosa of the gastrointestinal tract.

Laboratory tests reveal a hypochromic, microcytic anemia secondary to chronic blood loss. Bleeding time, clotting time, prothrombin time and platelets are almost always normal. Singer and Wolfson[21] reported three cases with a positive Rumpel-Leede tourniquet test. Wells[22] reported two cases with a positive tourniquet test, two with prolonged bleeding time, two with variable clot retraction, one with variable coagulation time, and one with decreased platelets.

Ecchymosis or bleeding into the skin is uncommon in Rendu-Osler-Weber's disease and this may help to differentiate from other hemorrhagic diseases. Frequently a tourniquet test on these people brings out small

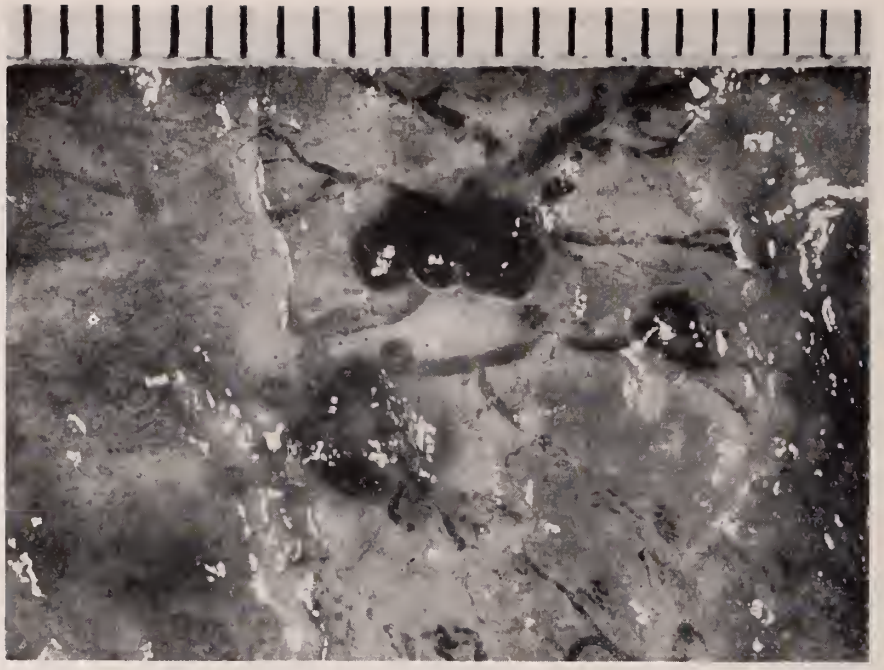


Fig. 5—Transaluminatian af the intestinal wall reveals the vascularity af the telangiectases.

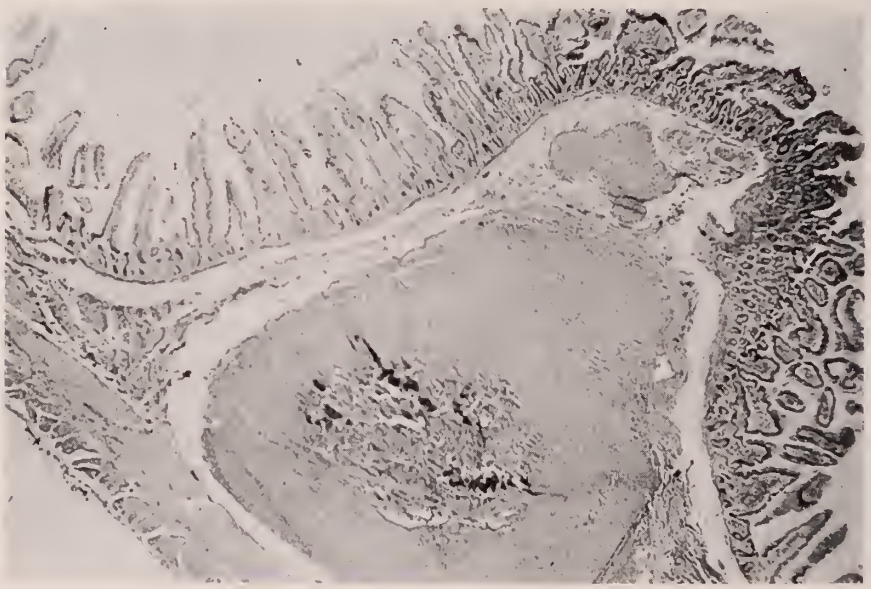


Fig. 6—Microscopic picture af telangiectasia in the intestinal tract.

telangiectatic areas previously not seen and some may bleed. Therefore, this may be incorrectly read as a positive test. Prolonged bleeding time can occur, if the telangiectatic area is punctured.

Other differentiating points are: hemophilia appears only in males and a delayed clotting time is present. In pseudohemophilia spontaneous ecchymosis is frequent and bleeding time is usually prolonged and the tourniquet test is frequently positive. In allergic purpura there is often a positive tourniquet test and a history of an allergen. The most differentiating point is that characteristic telangiectasia are not present in any of the above.

Another disease that may prove troublesome in differentiating from this is Schonlein-Henoch's syndrome. This is a syndrome characterized by purpuric lesions, gastro-

intestinal symptoms, and painful swelling of the joints. The purpuric lesions are caused by an increased permeability of the capillary endothelium secondary to an allergic agent, a protein. This protein may be a food, bacteria (frequently streptococci), or may be unknown. The dusty red macules on the skin are large and do not fade on pressure; therefore, the differentiation is usually not difficult.

Gastrointestinal tract telangiectasia can occasionally be diagnosed by gastroscopy and rarely by proctoscopy. X-rays will not show the lesions, consequently a positive diagnosis is usually made at surgery.

The diagnosis of pulmonary arteriovenous fistula can often be made by x-ray. Pulmonary densities with hilar vascularities should arouse suspicion, especially if there is change in size of the lesion after a Valsalva maneuver. The finding of a bruit over the lesion is important. Angiocardiography will usually establish the diagnosis; however, in capillary telangiectasia of the lung, angiocardiography may fail to show the lesion.

TREATMENT

Epistaxis is frequently difficult to control. Usually nasal packing is the simplest and most effective. Plummers[23] reported good results with the use of oral thrombin to control gastrointestinal bleeding.

Numerous systemic agents have been tried with equivocal results; e.g. calcium, snake venom, irradiation of the spleen, Vitamin K, Vitamin P, rutin,[17, 24] ACTH[25] estrogen and androgens.[26]

The spontaneous onset and cessation of hemorrhage, which is typical of this disease, makes evaluation of therapy extremely difficult. Blood transfusions to replace severe blood loss and iron preparations to aid in combating the secondary anemia seem to be the only universally accepted therapy.

DISCUSSION

One may question whether the five cases presented should be classified as hereditary hemorrhagic telangiectasia. If the diagnostic triad of: (1) hereditary, (2) hemorrhagic, and (3) telangiectases is used as criteria of diagnosis, only Case 1 will fall into this classification. Case 5 is almost identical to Case 1, except for a lack of hereditary background. Case 4 had no history of hemorrhage or the hereditary defect. Cases 2 and 3 had hemorrhagic telangiectasia, but no hereditary history of the disease. All five had identical findings of telangiectasia of the gastrointestinal tract; however, only two of these had severe bleeding episodes. It appears that this disease can present itself in a variety of ways. Therefore, the five cases presented can conceivably be classified as being Rendu-Osler-Weber's disease.

The patients exhibited telangiectasia in multiple areas: skin, brain, palate, tongue, lung, liver, gastrointestinal tract, vagina, and the urinary tract. Any one of these areas could, and frequently did, give rise to hemorrhagic manifestations.

Telangiectasia of the gastrointestinal tract are so extensive that rarely is resection possible. Frequently the bleeding site cannot be established at the time of surgery. It is therefore important to recognize this entity as a cause of gastrointestinal bleeding.

SUMMARY

The case histories of five patients with multiple telangiectases have been presented. The disease entity, hereditary hemorrhagic telangiectasia or Rendu-Osler-Weber's disease has been described as to history, incidence, hereditary aspects, etiology, pathology, classification, clinical course, diagnosis and treatment.

Although these people with hereditary hemorrhagic telangiectasia have a disability with recurrent blood loss and anemia, they ordinarily live out their usual life span. Occasionally one may die secondary to acute, severe hemorrhage. Houser,[27] in a review of the literature, estimates a 4 per cent mortality due directly to the disease.

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one of a series

ROENTGEN RIDDLE . . .

Fig. 1—Supine abdominal roentgenogram

HISTORY: A 65-year-old white man complained of intermittent lower abdominal pain which had persisted for 24 hours. There had been progressive abdominal distention and obstipation. Similar episodes had been experienced intermittently for the past two years. The patient had responded to catharsis and enemas, but this time the pain persisted. There was no previous history of abdominal surgery.

PHYSICAL EXAMINATION: Obvious distention of the abdomen with tympany and slightly increased intestinal sounds were evident. The vital signs were normal. A digital examination of the rectum was normal.

X-RAY: A supine abdominal anterior posterior roentgenogram revealed a large loop of distended intestine arising from the pelvis and which appeared bent upon itself. The proximal, mid and descending colon as well as some loops of small intestine showed some distention.

DISCUSSION continued on page 247

Carcinoid Syndrome and Hypertension

A Case Report

By OTTAR SJAASTAD, M. D. and S. E. SIVERTSON, M. D.
La Crosse, Wisconsin

HYPERTENSION has not been a recognized and accepted feature of carcinoid syndrome. At the moment, a causal relationship appears problematical; experimental evidence and the reporting of carcinoid syndrome associated with hypertension, however, suggest a kinship greater than chance. This communication records another case of carcinoid syndrome with both hypertension and apparent liver metastases of 15 years duration.

CASE REPORT

A caucasian farmer was 56 years of age at the time of a fatal illness characterized by chronic congestive heart failure and hypertension in 1960.

His medical history included surgery for a ruptured appendix in 1935. Several years later, spells of abdominal rumbling, intermittent pain, and diarrhea began. In August, 1945, when the attacks became disabling, he presented himself at a clinic whereupon he was hospitalized. The daily colicky abdominal pains were accompanied by gurgling abdominal sounds audible 'in the next room.' There was minimal belching and flatulence. Meals accentuated his distress, and reduced food intake led to loss of 20 pounds in weight. Blood pressure was 185/120, routine blood and urine studies were not unusual, and x-ray films of the gastrointestinal tract were negative except for distortion of the cecum. Exploratory laparotomy uncovered a mass of pericecal adhesions. Landmarks were obscured and a second mass in the small intestines posteriorly at the level of the second to third lumbar vertebrae was felt. Two hard raised nodules, about 1+ cm. in diameter, were palpated in the liver. The obstruction was relieved by lysis of adhesions, and the patient recovered. The surgeon felt that extensive carcinoma was present, but no biopsy was taken.

Months later, the same symptoms gradually returned and led to a second exploration of the abdomen in April, 1947, to relieve intestinal obstruction. Physicians in attendance were surprised that cachexia of malignancy had not supervened. At this time the blood pressure was 170/100 and the heart was thought to be slightly enlarged. Operative findings included massive adhesions and markedly distended small intestine crowding the abdominal cavity; it was necessary to resect a foot of small intestine and construct an ileostomy with a defunctioning hepatic colostomy. Microscopic studies of biopsied adhesions revealed lymph tissue containing metastatic carcinoma. The liver nodules were not biopsied.

Following this, his recovery was truly amazing. A ravenous appetite led to weight gain of 20 to 30 pounds and a return to vigorous farm work. In November, 1948, a third abdominal surgery reestablished intestine continuity, after which he gained another 10 to 20 pounds.

In 1955, the patient was first seen by one of us (S.E.S.). Exertional dyspnea and paroxysmal nocturnal dyspnea, gradual in onset, greatly interfered with his ability to work. His face was ruddy with prominent superficial blood vessels. His blood pressure varied from 174/122 to 190/120. The heart was enlarged to the left; he had no cardiac murmurs, but there was a gallop rhythm with numerous ventricular extrasystoles and short runs of tachycardia interrupting sinus rhythm. The liver extended 4 cm. below the right costal margin. The peripheral blood count, serology, routine urinalysis, and blood urea nitrogen were normal. Chest x-ray films showed generalized cardiac enlargement and

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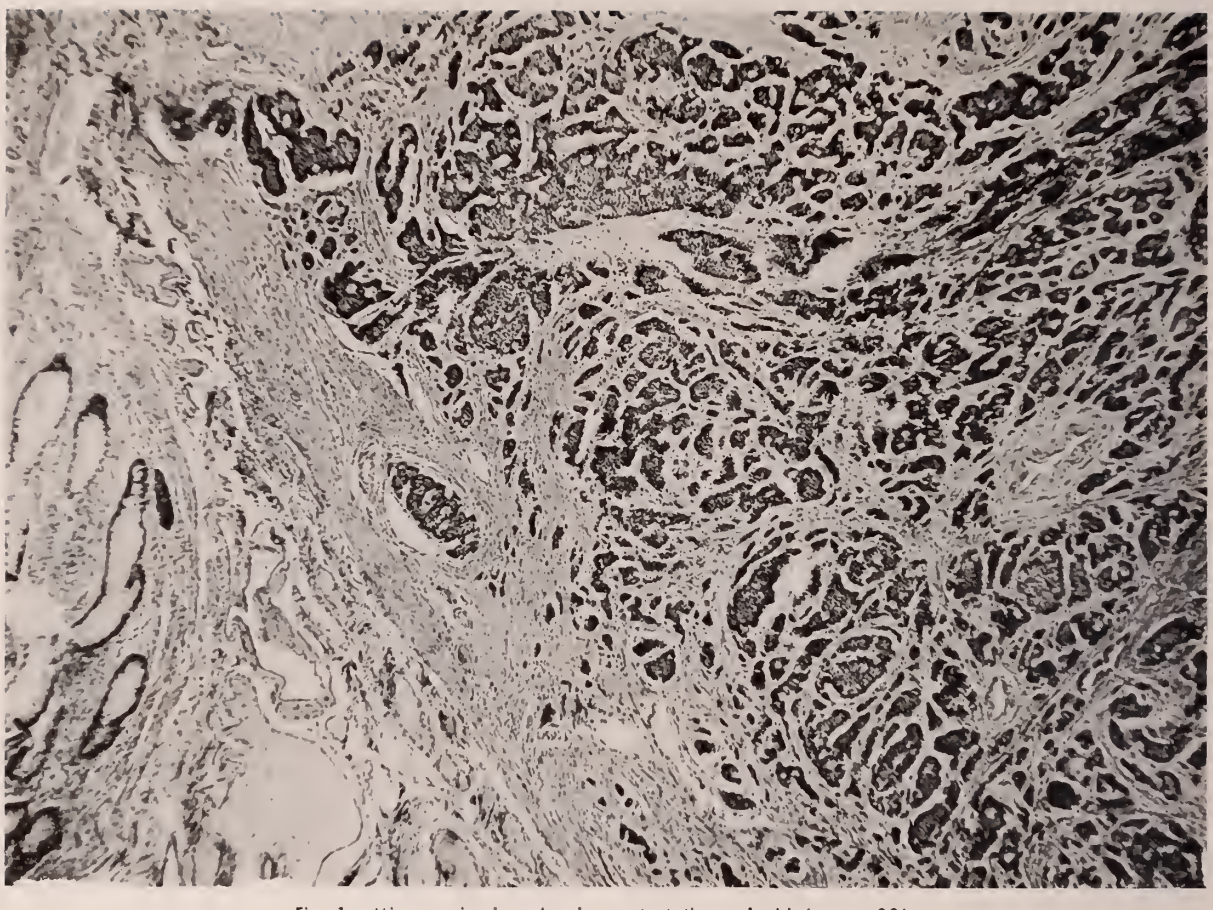

Fig. 1—Microscopic view showing metastotic corcinoid (mag. x32).

pulmonary congestion. An electrocardiogram revealed left ventricular hypertrophy and strain; transient upper atrioventricular nodal rhythm from overdigitalization was seen in subsequent electrocardiograms. Digitalization and mercurial diuretics led to diuresis with a 17-pound weight loss and marked improvement.

He was seen periodically as an outpatient and was progressing satisfactorily. His blood pressure ranged from 150/90 to 200/100.

He was not seen again until four years later; i.e., December, 1959, when recurrent congestive failure prompted his return. Wheezing and episodes of flushing, diarrhea, and abdominal distress had not been experienced. During the interval, he had continued with digitalis, diuretics, and various antihypertensive drugs prescribed by his local physician. Blood pressure at this time was 172/100 and he appeared cachectic. A noticeable redness discolored his face and neck. There was no evidence of ascites. A Grade 1 mitral systolic murmur was heard, and again, the hemoglobin level, hematocrit reading, white blood cell count, differential blood cell count, sedimentation rate, and routine urinalysis were within normal limits. Blood sodium was 142 mEq./l., potassium 3.8 mEq./l., carbon dioxide 25 mm./l., and chlorides 106 mEq./l. Serum alkaline phosphatase was 6.8 KA units and transaminase 0 units. Cardiomegaly, seen on the chest x-ray film at this time, was about the same as it was on a chest x-ray film taken four years previously. X-ray films of the colon, stomach, and small intestine disclosed irregular areas of narrowing in the ileum and sigmoid. Electrocardiographic studies failed to demonstrate significant changes from 1955. Pulmonary function studies showed the vital capacity to be 2.92 L, the maximum breathing capacity 55.4 L/minute, and the maximal midexpiratory flow rate within normal limits.

Reexamination of biopsy material obtained in 1947 revealed metastatic carcinoid. (Figs.

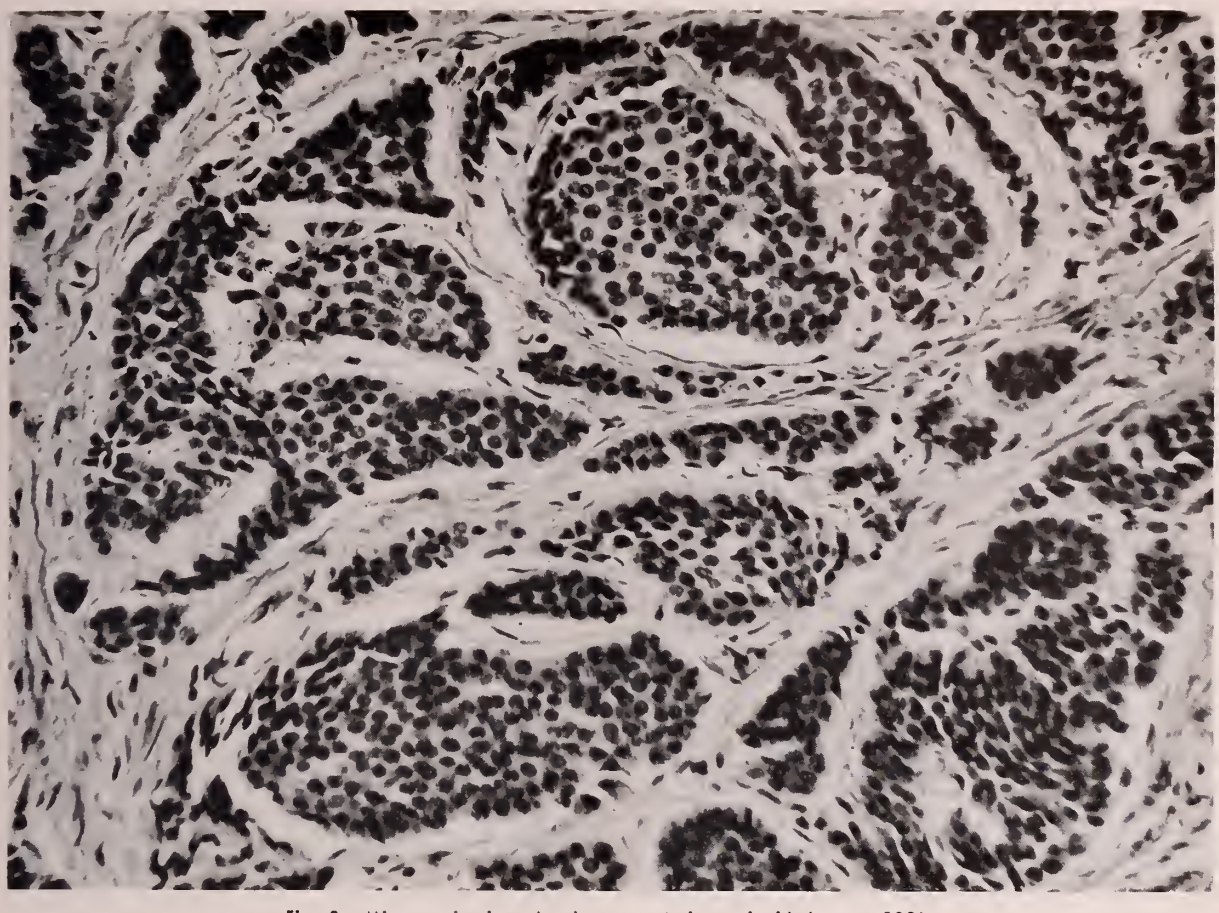

Fig. 2—Micrascapic view showing metastatic carcinoid (mag. x200).

1 and 2) Quantitative analysis of a 24-hour urine specimen found 189 mg. of 5-hydroxyindolacetic acid.

Blood pressure ranged from 150/85 to 190/110. The average of 22 measurements was 170/95, as compared to an average of 155/107 during the 1955 admission.

Signs and symptoms of congestive heart failure diminished as he responded to bedrest, digitalis, diuretics, and chlorpromazine. Subsequently it was learned* that five months after discharge he developed a flu-like illness for which he was hospitalized near home. He appeared to recover. To stimulate a poor appetite, 5 units of regular insulin were given and a surprising shock-like reaction followed. Steroid medications were administered, but some 12 to 24 hours later he died of a 'cerebral vascular accident.' No autopsy was performed.

*We are indebted to Dr. W. K. Dankle of Cresco, Iowa, for information concerning the terminal illness.

DISCUSSION

To those attending him, this patient's condition raised questions of a relationship between carcinoid secretions and hypertension accompanied by congestive heart failure. In addition, the long duration of known metastatic carcinoid tumor and subsequent development of carcinoid syndrome was unusual and worthy of a report.

Medical literature contains confusing information about serotonin and its influence on blood pressure. For nearly 100 years human serum was known to contain a vasoconstrictor principle. In recent years it was identified[1-5] and named 5-hydroxytryptamine (serotonin[6] or enteramine[1]). When given to animals, it caused systemic blood pressure to rise, fall, or do both, depending upon numerous factors, such as species, dose, and mode of administration;[7-11] in contrast, pulmonary arterial pressure in dogs was consistently and significantly elevated.[11]

In man, as independently demonstrated by Page and McCubbin[9] and Hollander, et al.,[12] intravenous serotonin produced a systemic depressor, depressor-pressor (biphasic), or pressor response, again depending upon multiple variables. How this is accomplished is not fully established. That the mechanism, at least in part, may be peripheral is suggested by its known ability to dilate capillaries and produce spasm of small arteries and veins.[13,14] In the lesser circulation again arterial pressure rises during the flush, as pointed out by Thorson.[15] On the other hand, Sjoerdsma[13] is not convinced that this effect is pronounced in man.

Clinically, hypertension in patients with carcinoid syndrome has not been considered a common feature.[13, 15-27] Some authors claim that systemic hypertension is not a part of it[13, 15, 28, 29] and others report a fall in blood pressure during flushes and in the final stages.[13, 15, 26, 30, 31] Moreover, patients with essential hypertension have been found to have normal blood serotonin levels.[32] On the other hand, Thorson[33, 34] found elevation of the systolic pressure and decrease of pulse pressure during the late stage of the flush.

Cases have been reported in which an elevated blood pressure was noted. Several of Waldenström and Ljungberg's[35] patients seem to be in this category as might be the case of Bean and Funk.[36] The ovarian carcinoid with Meigs's syndrome reported by Thorson, et al.,[37] had blood pressure variations from 135/80 to 220/110. In the original 16 cases of Thorson, et al.,[38] 8 had blood pressures reported and in 5 of these it was elevated; one man, 19 years of age, had a blood pressure of 140/105, while a 63-year-old man showed a varying pressure of 150/100 to 220/140. In a more detailed study of 79 cases, Thorson[15] does not elaborate on blood pressure behavior in carcinoid syndrome. Of the four cases of Sauer, et al.,[22] two might be considered hypertensive and in one of these the pressure was 235/97.

After reviewing case reports, one is impressed that perhaps not enough attention has been given to blood pressure changes in this syndrome. Perhaps the blood pressure fluctuates markedly as it appears to do when serotonin is given to animals, and its value depends upon the time at which it is obtained. It is interesting to speculate that serotonin from carcinoid tissue may bypass the lungs through various right-to-left shunts and produce a systemic pressor response. The patient presented was originally misdiagnosed as having hypertensive heart disease with congestive heart failure and treated as such; it is possible that hyperserotonism added to or was superimposed on an already failing heart.

It is emphasized that liver metastases are essential to vasculocardiac changes produced by carcinoids. It might also be true that liver metastases may produce no systemic effect, as suggested by Case 8 of Sauer, et al.[23] Although the original description of the syndrome included flush and asthma, Sauer, et al.,[22] has reported patients in which these dramatic events were not present or occurred independently. This patient, with no episodic flush and asthmatic wheeze, was unusually florid, suggesting a peripheral vascular response in the face and neck.

Prominent borborygmus and intermittent diarrhea were experienced prior to his first admission. These may have resulted from partial intestinal obstruction rather than from serotonin. The hypertension, as well, could have been independent of the carcinoid in this case. While it is not possible to quantitate the causative role of the tumor, there can be no doubt that his carcinoid tissue was secreting serotonin, as testified by the relatively large amount of 5-hydroxyindolacetic acid in the urine. This, together with elevated blood pressure, chronic congestive heart failure, carcinoid tumor with metastases, and dark red countenance, strongly suggests a causal relationship in this patient. Unfortunately, an autopsy with biochemical tissue assay was not done.

Patients with carcinoid tumors live long. Both Mallory[39] and Thorson[15] have seen patients survive 20 years with local metastases and Rosenbaum[21] observed hepatomegaly for 10 years in one patient. In Terplan's[40] case numerous metastases in lymph nodes and liver were unchanged over five and one-half years. Survival after diagnosis of carcinoid syndrome is shorter, five to six years.[15, 17, 19, 22, 23, 27, 29, 35, 38] We are not aware of a patient with liver metastases surviving as long as the patient reported here.

SUMMARY

This is a report of a case of carcinoid tumor with local and apparent hepatic metastases of 15 years duration. The carcinoid

tissue ultimately produced hyperserotonism without episodic flush and asthma; it mimicked hypertensive heart disease with congestive heart failure and suggested a relationship between serotonin and labile hypertension in man.

(S.E.S.) 1836 South Avenue.

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CLINICOPATHOLOGIC CONFERENCE

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Green Bay, Wisconsin

CASE PRESENTATION*

Dr. S. L. Griggs (Pediatrician): This seven-year-old girl was admitted to the hospital in May, 1957, at which time she had pain, swelling and palpable warmth of the lower third of the right humerus. She had fallen at a playground three weeks earlier. Since that time she had splinted the arm voluntarily.

On admission, the significant physical findings were confined to the right lower humerus. The abdomen and thorax revealed no abnormalities. X-ray films of the arm showed "marked soft tissue swelling, elevation of the periosteum, and minimal cortical bone destruction suggesting acute or subacute osteomyelitis." (Fig. 1)

Examination of the blood revealed a hemoglobin level of 11 gm. per 100 ml., red blood cell count of 3.4 million, white blood cell count of 9,200 with a normal differential, and an erythrocyte sedimentation rate of 60 mm. in one hour. Urinalysis, blood cultures and tuberculin skin test were all negative.

An initial fever of 102 F. subsided on treatment with antibiotics. The right humerus and overlying soft tissue remained swollen, hot and painful. Tissue was taken for biopsy and interpreted as an "osteolytic sarcoma of periosteal origin." (Fig. 2)

The patient was transferred to a hospital in another city where the biopsied material was regarded as "Ewing's tumor, (sarcoma) of bone." The child's right, distal, upper arm was given extensive deep x-ray therapy and the tumor regressed completely. She appeared asymptomatic. In the spring of 1958, one year after onset of her illness, the arm again became enlarged, hot and painful. Again x-ray therapy was used with complete resolution of the lower humerus lesion.

In November, 1958, the patient was readmitted to the first hospital with abdominal distress. A palpable mass in the left upper quadrant of the abdomen was discovered. X-ray films of the abdomen and excretory urogram demonstrated a retroperitoneal mass which displaced the left kidney downward, forward, and laterally. (Fig. 3) Physical examination on this admission revealed an enlarging tumor which now occupied the entire left upper quadrant. It was firm and only moderately moveable. Pigmentation of the skin of the right, distal, upper arm was noted.

Tissue taken from the abdominal mass for biopsy revealed it to be a "retroperitoneal reticulum cell sarcoma." (Fig. 4) At surgery the mass displaced the left kidney forward and downward. The tumor was vascular with central hemorrhage and necrosis. It was adherent posteriorly to the aorta, renal artery and pancreas. The mass measured 12 cm. in diameter. Cobalt irradiation therapy was administered with good initial reduction in the size of the tumor.

The child's last admission was in August, 1959, for persistent vomiting and abdominal pain. She became comatose and had a continuous downhill course with fecal vomiting and dehydration. On Sept. 25, 1959, she died.

DIFFERENTIAL DIAGNOSIS

Dr. J. E. Kaufman (Orthopedic Surgeon): This seven-year-old girl was admitted to the hospital in May, 1957, with pain, swelling and palpable warmth of the lower third of the right humerus of three weeks duration. There is a vague history of trauma three weeks prior to that. Her temperature on admission was 102 F. and the blood studies were essentially normal except for an increase in erythrocyte sedimentation rate. The x-ray film of the involved arm showed an elevation of the periosteum, soft tissue swell-

*From St. Vincent Hospital, Green Bay.

Fig. 1—Initial film study (May 21, 1957) obtained prior to biopsy demonstrating destruction and irregularity of the cortex along the posteromedial aspect of the lower humeral shaft, with bone production, and soft tissue swelling.

ing, and minimal cortical bone destruction. At first it was thought to be an osteomyelitis, since the fever subsided after antibiotic therapy. When the complaints of the patient and physical findings of the arm persisted, tissue for biopsy was taken and the histological report was that of osteolytic sarcoma of the periosteum.

It is not unusual to have a case of malignancy showing signs similar to that of an infection. I am unable to explain why the temperature subsided after antibiotic therapy, unless the fever was due to some other cause.

Osteolytic sarcoma of the periosteum is a rare tumor but the x-ray findings substan-

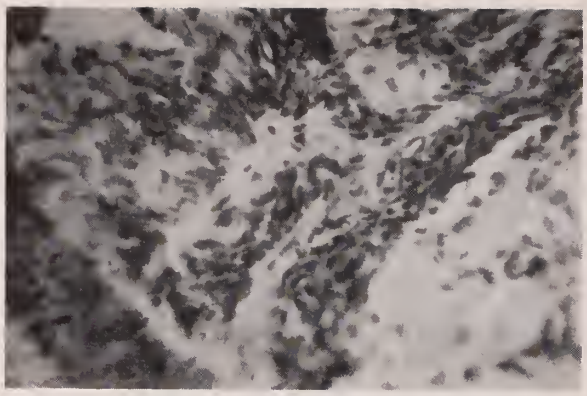

Fig. 2—Microscopic view showing lesion of humerus.

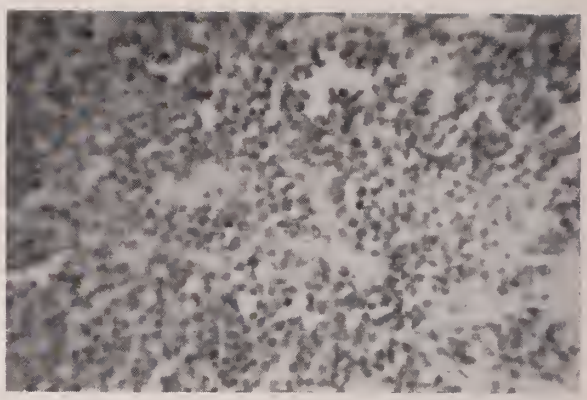

Fig. 4—Micrascapic view shawing lesion of abdomen.

Fig. 3—Excretory urogram (Dec. 4, 1958) demonstrating enlargement of the left kidney and displacement of this kidney by large retroperitaneal mass.

tiate this conclusion. They show a tumor arising outside of the bone from the periosteum and invading the soft tissue and the bone. The patient was then transferred to another hospital where a diagnosis of Ewing's tumor was made. Possibly the histological findings influenced this diagnosis since the x-ray picture of Ewing's tumor usually shows widespread areas of rarefaction with periosteal reaction. The early x-ray films of this tumor taken at the first hospital did not show that. The tumor then responded to x-ray therapy. This fact could justify the diagnosis of Ewing's tumor. When the tumor recurred at the same site, the patient again was given x-ray therapy with good results.

The differential histological diagnosis between Ewing's tumor and reticulum cell sarcoma is at times difficult to make. We realize now that we were not dealing with a primary Ewing's tumor of the arm, but rather with a metastatic lesion, because Ewing's tumor usually metastasizes to other bones and to the lungs, not to the retroperitoneal area. In this case the metastatic lesion became apparent much earlier than the primary lesion.

I would accept the diagnosis of a reticulum cell sarcoma on the basis of the biopsy report. However, one must also consider a neuroblastoma in the differential diagnosis, since in children this is often confused with Ewing's and reticulum cell sarcoma. Histologically these are difficult to differentiate. Neuroblastoma metastasizes to the skull and long bones as well as to the lymph nodes. One point favoring this last diagnosis is the fact that the neuroblastoma may originate in any part of the sympathetic nervous system and in the adrenal.

In this case the retroperitoneal tumor pushed the kidney downward and forward, suggesting that we were dealing with an adrenal tumor. Toward the end, the tumor involved the gastrointestinal tract resulting in fecal vomiting.

The significant point in this case is that we were considering a metastatic tumor as a primary tumor. I believe it is a mistake to amputate in cases of Ewing's tumor, and in this patient it would have been compounding the error. My clinical diagnosis is neuroblastoma of left adrenal gland with metastasis to the right humerus and with extension to the gastrointestinal tract.

AUTOPSY FINDINGS

Dr. John L. Ford: This was a well developed, but extremely emaciated, white female child of seven years of age. A large mass was palpable in the left upper quadrant. Over the right humerus there were several dark areas of skin discoloration, apparently a post-irradiation effect. The arms and legs had a large amount of hair for a subject of this age. The peritoneal cavity contained approximately 800 ml. of sanguineous fluid and the stomach contained approximately 700 ml. of dark red blood. Several small shallow ulcerations of the stomach were noted. The entire gastric mucosa was hemorrhagic. The proximal duodenum was filled with dark red blood and the duodenal wall was necrotic. Nine cm. from the pylorus there was a great mass of necrotic tumor tissue forming the wall of a cavity into which many loops of intestine penetrated. The splenic flexure of the colon was destroyed and necrotic. Several loops of small intestine also entered this area. The remaining intestine was bound together by enormous masses of adhesions. Many of the mesenteric vessels were occluded and there was a marked degree of lymphoid hyperplasia of the adjacent mesenteries. The wall of the tumor itself was thick and fibrous, had a friable, crumbling necrotic appearance, and was lined by dark brown necrotic mucosa and feces. The various loops of intestine, the superior aspect of the right kidney, and the spleen surrounded this mass of necrotic tissue. A marked degree of fibrosis bound all of these structures into a solid mass which contained a central necrotic cavitation. The left kidney itself was normal in appearance, but the anterior superior aspect was involved in the tumor mass which also encroached upon the left ureter, producing a moderate degree of left-sided hydroureter involving the superior half of the ureter itself. The left adrenal gland was not identified. There was no evidence of visceral metastases, either in the chest or abdomen. Postmortem examination of the brain was not authorized.

The microscopic sections corroborated the gross anatomical diagnosis of neuroblastoma. Sections through the tumor mass in the area of the left adrenal gland revealed cords and clusters of small round cells which showed frequent mitotic division. An occasional field showed as many as five mitotic figures per high-power field. Many of these small cells tended to form rounded structures, the so-called "rosettes." Among the tumor elements were a few surviving ganglion cells which occurred in small clusters and served to identify the origin of the tissue. These ganglionic elements were intact, were surrounded by a thin capsule, and were composed of many mature large neurons among which were small round cells, similar to those seen in the tumor itself. The many malignant nervous elements indicated a sympathoblastoma and the location adjacent to the kidney placed the tumor as an adrenal neuroblastoma.

Many additional sections taken from the left upper quadrant of the abdomen showed malignant tumor elements of a similar nature among which were large areas of necrosis. The tumor itself was vascular and in the

areas of necrosis there were small arteries which were thrombosed and filled with polymorphonuclear leukocytes. In other areas the tumor was composed almost entirely of small round cells resembling lymphocytes which were probably sympathogonioma cells. In some of the more necrotic areas the cells had a pale staining reaction, were relatively large, and bore a striking resemblance to reticulum cells. Sections through the liver showed a profound degree of fatty change. Almost every polyhedral cell contained a large vacuole and there were vacuoles between the hepatic cells in which there was stored lipid, simply a deposit of fat.

ANATOMICAL DIAGNOSES

1. Hirsutism, arms and legs.
2. Postirradiation status (pigmentation of skin, right distal upper arm).
3. Emaciation.
4. Postlaparotomy status (left rectus surgical scar).
5. Neuroblastoma (mixed sympathogonioma and sympathoblastoma type) of left adrenal medulla with extension to the adjacent viscera.
6. Ascites, 800 ml.
7. Pericardial effusion, 100 ml.
8. Pressure necrosis, obstruction, hemorrhage, abscess formation and tumor metastasis encompassing the distal duodenum, jejunum, various loops of ileum, and splenic flexure of colon.
9. Multiple mesenteric abscesses.
10. Multiple punctate ulcerations of the gastric mucosa.
11. Excoriations of facial skin.
12. Venoclysis incisions over medial malleoli of ankles, bilateral.
13. Mesenteric lymphadenopathy.
14. Exsanguination (massive gastrointestinal hemorrhage).

PATHOLOGICAL DISCUSSION

Dr. John L. Ford: The adrenal medulla has its origin from ectoderm in common with sympathetic nervous tissue. The cells of the adrenal medulla stain with chrome salts as do some other tissues such as the abdominal paraganglia. They produce epinephrine and norepinephrine which are not essential to life. Any functional disturbance of the medulla caused by destructive lesions of the adrenal is overshadowed by the effects of cortical involvement, e.g. the tuberculous type of Addison's disease. The only lesions of practical importance in the adrenal medulla are tumors. There is decreased activity of the medulla in neoplastic diseases and prolonged infections. High activity is observed in cerebral injuries, diabetes, obesity, hypertension and hyperthyroidism.

Tumors of the adrenal medulla arise in mature or immature cell types. The most immature cell types are the sympathogonia which differentiate into sympathicoblasts and pheochromoblasts. The sympathicoblasts mature as ganglion cells and the pheochromoblasts develop into pheochromocytes. Tumors made up of the more immature forms such as sympathicogoniomas and neuroblastomas occur in early life and are highly malignant. The sympathicoblastoma is less malignant than the sympathogonioma, especially when it occurs in later periods of life. Those composed of the mature forms, the ganglioneuromas and the pheochromocytomas, are benign and occur mainly in adult life.

Neuroblastoma or sympathicoblastoma is a highly malignant tumor which arises in the adrenal medulla or immediately adjacent. It is an extremely cellular tumor composed of small dark-staining cells resembling lymphocytes and it has the characteristic feature of forming small circular groups of cells (the so-called pseudorosettes) around a fine fibrillar network. It differs from the sympathogoniomas only in its somewhat greater maturity. The medulloblastoma of the midbrain and the retinoblastoma of the eye are also malignant tumors which arise from undifferentiated neural elements, have a similar histological structure, and occur in childhood. Because of the difficulty in differentiating the neuroblastoma from lymphosarcoma, Ewing's tumor and osteogenic sarcoma, which are all very similar histologically, it has been advocated that the cells of neuroblastomas be cultivated in vitro.

Neuroblastoma is the most frequent tumor of the sympathetic system in childhood. Young children are most often affected, and it is estimated that about 80 per cent of the cases are observed in the first two and one-half years of life. Among the remaining 20 per cent of cases, the majority of these occur in older children, but an occasional case is noted in adult life. It appears to occur more frequently in females than in males. The abdominal enlargement is usually due to

metastasis to the liver but occasionally is due to the original tumor mass itself and to the accompanying ascites. The metastatic lesions of the skull produce an outward growth under the scalp. When metastases occur in the long bones, there is usually pain, local enlargement, cortical destruction, and possibly a pathologic fracture. Exophthalmos in these cases can result from orbital tumor but also may be independent of it. A moderate anemia with leukocytosis and elevated temperature is frequent. On the basis of distribution of the lesions, two clinical groups of neuroblastomas have been proposed. These are known as the Pepper and Hutchinson groups. In the Pepper group, there is early and extensive metastasis to the liver resulting in abdominal enlargement. In the Hutchinson group there is metastasis to the skull, dura, long bones and occasionally to the lungs. Exophthalmos may be present. However, there is much overlapping of these two groups of cases. There appears to be a difference in age incidence since neuroblastomas which metastasize to the liver and soft tissues usually occur in younger children, whereas those which metastasize to the skull and long bones seem to occur in older children.

We can learn one important thing from this case presentation: when a single bone lesion is noted in a child, we must think of Ewing's sarcoma, neuroblastoma, osteolytic-osteogenic sarcoma, and reticulum cell sarcoma. Microscopically, Ewing's tumor is composed of small round cells in the form of broad and narrow sheets of cells, a well-vascularized stroma is present, and there are numerous mitotic figures. Neuroblastoma is composed of cells which are larger, more irregular in contour. There is a fibrillar network surrounding pseudorosettes. Osteolytic-osteogenic sarcoma is highly cellular and there is some osteoid matrix between the masses of cells. The cells in these lesions are relatively pleomorphic. In reticulum cell sarcoma the cells are larger than lymphocytes and have cytoplasmic processes, suggestive of reticulum as their origin. Sometimes in these cases giant cells are present.

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ROENTGEN RIDDLE *continued from page 236*

DISCUSSION: The roentgen findings are those seen in acute sigmoid volvulus. Volvulus or twisting of the intestines is an uncommon cause of intestinal obstruction. Volvulus can involve the stomach, small intestine or large intestine. The sigmoid colon is most frequently involved. Sigmoid volvulus accounts for approximately 5 per cent of large intestinal obstructions. The incidence is greatest in the elderly male. Predisposing factors for the precipitation of volvulus are a long redundant overdistended loop of sigmoid colon whose limbs are closely approximated by a fixed narrow mesentery root. Precipitating factors as excessive purgation, chronic constipation or associated pelvic masses complete the circumstances favoring the occurrence of acute sigmoid volvulus.

A roentgen abdominal series is generally quite specific. The most significant finding is the huge dilated loop of sigmoid colon rising out of the pelvis and occupying the mid abdomen. One limb ascends from and another limb descends into the pelvis. This feature has been described as resembling a bent inner tube. Not all cases are characteristic roentgenographically, but when suspected, findings on barium enema examination are diagnostic. A partial or complete obstruction is found at the distal sigmoid colon. There is a spiral or twisted mucosal pattern a short distance from the point of obstruction. The narrowing at the point of obstruction is abrupt and has been compared with the appearance of a bird's beak.

The common causes of acute large intestinal obstruction in the aged are carcinoma, diverticulitis, strangulated hernia, and intussusception. None of these produce as characteristic a roentgen sign as acute sigmoid volvulus on the abdominal series.

TREATMENT: Treatment of the acute stage is reduction by nonoperative or operative methods. It is generally agreed that an attempt at reduction with the sigmoidoscope followed by the insertion of a long rectal tube should be done. Follow-up films of the abdomen confirm reduction. Perforation is cited as a complication. If the mucosa is noted to be necrotic at sigmoidoscopy, operative reduction is advised. The mortality rate for primary resection in the acute stage is near 40 per cent. Thus acute sigmoid volvulus is a serious problem.

Because of the tendency to recurrence an elective removal of the sigmoid colon is advised even if nonoperative reduction is successful.

areas of necrosis there were small arteries which were thrombosed and filled with polymorphonuclear leukocytes. In other areas the tumor was composed almost entirely of small round cells resembling lymphocytes which were probably sympathogonioma cells. In some of the more necrotic areas the cells had a pale staining reaction, were relatively large, and bore a striking resemblance to reticulum cells. Sections through the liver showed a profound degree of fatty change. Almost every polyhedral cell contained a large vacuole and there were vacuoles between the hepatic cells in which there was stored lipid, simply a deposit of fat.

ANATOMICAL DIAGNOSES

1. Hirsutism, arms and legs.
2. Postirradiation status (pigmentation of skin, right distal upper arm).
3. Emaciation.
4. Postlaparotomy status (left rectus surgical scar).
5. Neuroblastoma (mixed sympathogonioma and sympathoblastoma type) of left adrenal medulla with extension to the adjacent viscera.
6. Ascites, 800 ml.
7. Pericardial effusion, 100 ml.
8. Pressure necrosis, obstruction, hemorrhage, abscess formation and tumor metastasis encompassing the distal duodenum, jejunum, various loops of ileum, and splenic flexure of colon.
9. Multiple mesenteric abscesses.
10. Multiple punctate ulcerations of the gastric mucosa.
11. Excoriations of facial skin.
12. Venoclysis incisions over medial malleoli of ankles, bilateral.
13. Mesenteric lymphadenopathy.
14. Exsanguination (massive gastrointestinal hemorrhage).

PATHOLOGICAL DISCUSSION

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Because of the tendency to recurrence an elective removal of the sigmoid colon is advised even if nonoperative reduction is successful.

Editors
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COMMENTS ON TREATMENT

Local Anesthetics; Some Basic Concepts

By HAROLD F. HARDMAN, M. D., Ph. D.
Milwaukee, Wisconsin

IN MATHEMATICS the concept that the whole is equal to the sum of its individual parts is not difficult to comprehend. This concept is equally valid in pharmacology but only in recent years have investigators been able to demonstrate that many of our useful drugs exist simultaneously in several forms in the body and the individual forms possess distinct pharmacological properties.

The local anesthetics will serve as an illustration of this concept. Procaine is generally administered as a water soluble hydrochloride salt. When it is injected into body tissues, it dissolves in extracellular fluid which has a pH of approximately 7.3. In this slightly alkaline medium the drug undergoes immediate changes resulting in two distinct molecular forms. One form carries a positive charge and is referred to as the ionized form of procaine. The other form of the drug is unchanged and is termed the nonionized form of procaine. The ratio of the ionized to the nonionized form is determined by the ionization constant of the drug which is dependent upon the molecular configuration of the drug and can be considered a physical constant. A second factor, the pH of the environment, also influences the ratio of ionized to nonionized drug. For example 100 mg. of procaine hydrochloride injected subcutaneously into an environment having a pH of 7.3 will be converted to 98 mg. of ionized procaine and 2 mg. of nonionized procaine. The same dose of tetracaine hydrochloride under identical conditions will be converted to 94 mg. of ionized tetracaine and 6 mg. of nonionized tetracaine. Similar calculations for other local anesthetic agents reveal a correlation between the amount of drug present in the nonionized form and local anesthetic potency. Attempts to anesthetize an infected area with procaine may at times be disappointing. This can be explained on the basis that the pH of the extracellular fluid in an infected area becomes more acidic due to the production of acid metabolites such as lactic acid by the bacteria. Thus the pH of the infected area may fall to 6.8 and under these circumstances the injection of 100 mg. of procaine hydrochloride will result in the formation of 99.4 mg. of ionized procaine and 0.6 mg. of nonionized procaine. Once again a correlation between effectiveness and the amount of drug present in the nonionized form is observed. This type of evidence has resulted in the popular opinion[1, 2] that the nonionized form or free base is the active form of the local anesthetic agents. Ritchie and Greengard[3] (1961) have now provided conclusive evidence that it is the ionized or charged form of procaine, tetracaine and dibucaine which depresses and blocks the action potential of myelinated and nonmyelinated mammalian nerve fibers. The different evidence can be resolved into a single acceptable theory when one considers the uncharged or nonionized form of procaine to be necessary for transportation of procaine to its site of action. Shideman[4] reviewed the concept of permeability of renal tubular cell membranes to nonionized drug forms and impermeability to ionized drug forms in this column last year. The basic principles also apply to the permeability of nerve cells to drugs. Nonionized procaine readily crosses cell membranes and tissue barriers because it is neither attracted nor repelled by charged groups in the protein layers of cell membranes and it diffuses through lipid barriers according to the concentration gradient of uncharged drug across these barriers. Once the uncharged drug enters the cytoplasm of the nerve cell, it reionizes according to the pH of the axoplasm so that both ionized and nonionized

procaine eventually are found within the nerve cell. The presence of both forms, ionized and nonionized, of local anesthetic agents is necessary for clinical effectiveness. Those agents which are employed for topical anesthesia have a higher proportion of the drug in the nonionized form than does procaine under the same conditions. The presence of acidifying chemicals (Phisohex) in open wounds or on mucous membranes will antagonize the effectiveness of ionizable topical anesthetic agents because Phisohex lowers the pH of the environment to the point where very little of the local anesthetic agent can exist in the nonionized form. Under these circumstances the local anesthetic agent cannot penetrate the tissue barriers to reach the nerve cells.

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RAPID TESTS FOR BLOOD GLUCOSE

J. B. Strong and B. R. Boshell, VA Hospital, Birmingham, Ala. Journal of the Medical Association of Alabama, 31:9, 1961.

A rapid and quantitative bedside technique for the determination of levels of blood glucose in the range of 100 to 200 mg. per 100 ml., Dextrotest, compares favorably in accuracy with the Somogyi-Nelson method and a mechanized automatic method, employed in clinical laboratories. The Dextrotest kit comes supplied with the necessary reagents and equipment; i.e., 2 calibrated test tubes, 2 tablets, filter paper, and color scale. Tablet "P" containing sulfosalicylic acid and sodium bicarbonate is dissolved in test tube "P," and freshly drawn or anticoagulated blood is added to the 3 ml. mark. The tube is shaken vigorously and the mixture of precipitated proteins is filtered into test tube "S," which is flared at the top. When filtrate reaches the 1 ml. mark, tablet "S" containing copper sulfate, sodium hydroxide, sodium bicarbonate, and citric acid is added. This reaction will cause boiling in the mixture. After boiling ceases, the tube is shaken gently but thoroughly, and the resultant color is matched to a color scale in exactly 30 seconds.

A *blue color* is equivalent to 100 mg. per 100 ml. of blood sugar; a green color to 150 mg. per 100 ml.; and a brown color to 200 mg. per 100 ml. Intermediate levels may be estimated and, for levels exceeding 200 mg. per 100 ml. of blood sugar, the blood may be further diluted. A 20 mg. per 100 ml. lower value is expected when using the Somogyi-Nelson technique, since the latter yields "true" blood glucose values rather than total blood reducing substances. The simplicity of operation and low cost of the Dextrotest procedure make it ideal in emergency ward situations, in management of the patient with diabetic coma, and for the physician who does not have laboratory facilities in his office.—Labquick, Vol. 2, No. 1.

MACROCYTOSIS AND HEPATIC DISEASE

J. R. Bingham, Toronto Western Hospital, Toronto, Ontario, Canada. Canadian Medical Association Journal 85:178, 1961.

Abnormally large erythrocytes in the blood are associated with disorders of the liver and biliary tract. Three types of macrocytes, thin, thick, and target-shaped, have been observed, each with a cell diameter of at least 7.6 microns. Thin macrocytosis is characterized by the appearance of flattened erythrocytes with an increased diameter, decreased density, and normal cell volume. Damage to the parenchymal cells of the liver is believed responsible for this condition which clears up following cell repair. Nutritional deficiency results in the transformation of the thin macrocytes into thick macrocytes, and a blood picture similar to that found in patients with untreated pernicious anemia. Thick macrocytosis disappears with improved dietary habits although thin macrocytosis remains as long as hepatic parenchymal cell disease persists. Prolonged biliary obstruction produces an exaggerated type of thin macrocyte, seen as a central core of hemoglobin, surrounded by a transparent ring and a peripheral ring of hemoglobin, giving the appearance of a target. Obstruction may precede or follow the hepatic cell damage. Target cells are no longer visible when obstruction is relieved. The formation of target macrocytes occurs in the peripheral circulation while the formation of thin and thick macrocytes occurs in the marrow.—Labquick, Vol. 2, No. 1.

PRESIDENT'S PAGE

Who Is Out of Step?

LANGUAGE, written or spoken, is not only a thing of beauty but without it man might still be swinging from one branch to the other. Just as there is no recorded evidence of who first discovered the wheel—certainly one of the great inventions of all the ages—so no one knows the origin of the spoken or written word.

It does not seem too difficult even for those of us quite unfamiliar with the science of speech to imagine some of the early beginnings of the spoken word. For the basic emotions of pain and joy, anger and sorrow evoke basic sounds in all tribes of the human race as well as in other species of the animal kingdom. The progressive development and refinement of language both written and spoken from that crude beginning or when sparked by our Creator, has placed at our command a most wonderful instrument, but only if we grasp it and use it effectively.

Winston Churchill, that great architect of English prose, admits that his academic shortcomings at one period in his life required his devoting an inordinate amount of time to the study of English, and thus he learned the language and acquired the ability to be magnificently articulate. We would do well to emulate his efforts and acquire a potent weapon for presenting the case for a free social order.

If we are not willing or able to meet the challenge of the voluble prophets of the welfare state, by the very nature of our default we permit a void to develop and be filled by these modern day "medicine men" with their panaceas for a suffering and receptive mankind—receptive because they are getting the message in only one key.

When you and I were very young, we knew quite readily that if one wanted to be a policeman or truckdriver or locomotive engineer when he grew up he did so by simply wanting to be one. But when we asked those wonderful people, our parents, who seemed all wise at that early age how one became a doctor or teacher or pastor, we were told this required an "inner call." Perhaps to some in the giving of the advice it meant a call to true dedication and service, and to others more cynically inclined it meant forsaking any material wordly rewards, but to the wide eyed youngster it would be a mysterious voice that urged him on and would remain a mystery throughout his lifetime.

There was a time when this call and the whole hearted response to service was all that was needed to satisfy the physicians longing, and society left him to his sometimes unrewarding and often thankless task. But we are living in another world today. Not only the medical profession but also many other skilled groups such as business, industry and farming are being dominated by the avant-garde existentialists of the new world philosophy who assert that their theories and control can do it all so much better.

These zealots have been referred to by many as "unprincipled idealists," but they cannot be dismissed lightly with a euphonism such as this. A handful of these individuals, 27 physicians in number, met recently in the Hollywood atmosphere of Washington, D. C. to assure the greatest candlepower of the political spotlight, and announced their glowing support of the administration's medical care plan for over 65 group tied to social security. This was accompanied by several thousand words castigating the great majority of their colleagues, slurring the motives of anyone disagreeing with their philosophy, and denouncing organized medicine in the form of state and national organizations because they "had no voice in the ruling hierarchy of the A.M.A.!"

How ridiculous can one be? These men know or should know that they have everything to say about the delegates, board of

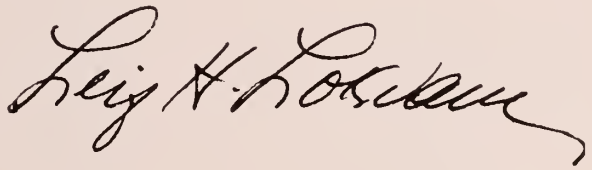
trustees and staff that do their bidding. This is just as clear cut as our voting for our representatives in government. Simply because an overwhelming majority do not agree with their group of 27 does not mean rule by executive decree.

But this is not the greatest danger to our social order! How can it be that a small group of 27 physicians is immediately accepted by government spokesmen, other self serving groups and, sadly enough, even some large segments of the press, who would have us believe they speak with all the knowledge and wisdom of the oracle, while the rest of us are living in grievous error. It would seem as the prejudiced mother remarked, as she watched her boy in the military parade, "Why, everybody's out of step but Johnny!" We often feel compelled to join with the philosopher who cried out "truth always on the scaffold—wrong always on the throne!"

Responsible candidates and office holders of both major political parties assert that too many physicians are unwilling to take a position publicly in defense of the philosophy of medical service free of the fetters of political domination; that they are unwilling to seek out the candidates or representatives in government and inform them of their personal convictions as a physician and citizen in forceful lucid language; that they hesitate to translate this symbolism of thought and word into action by participation in the campaign of the candidate who shares his philosophy.

What can we do? We must be vocal, we must be articulate, and more than this we must be willing to challenge our adversaries and meet them individually and collectively in any organization, club, forum or political group to seek them out and come to grips on the issue of politically controlled medical services so that the public may be properly informed. This can be more effective than depending on our state and national organizations to carry the total brunt of the battle.

Though one may never aspire to emulate the rolling thunder clap embodied in the Churchillian phrases, nor hope to capture the beauty in the poet's or songwriter's outpouring of the heart, we should most certainly be able to say what we mean and mean what we say.



THE DANGERS OF SPECIFICITY

The flow of new and potent drugs today compels the physician to continue his postgraduate education as he never had to before. The more specific the drug —and every effort of pharmaceutical research is bent toward making drugs more pinpointed in action against particular conditions—the greater the likelihood of some unwanted side reaction. . . Much pharmaceutical advertising warns the buyer not to use the product. It's rather like an ad for a washing machine which says, "This is a good washing machine but don't put a shirt into it or you may ruin it. It does a good job on sheets but is lousy on socks."—WILLIAM B. GRAHAM, President, Baxter Laboratories.

TODAY'S MEDICAL ECONOMICS

One of the critical problems facing medicine today is the growing tendency of the working man to equate health care with a municipally owned service while at the same time demanding discount house prices.—JUSTIN C. SMITH, Dean, Law-Medicine Center, Western Reserve University.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Good Samaritan

CHANCE ARRIVAL at the scene of an accident presents most doctors with a disconcerting choice between humane duty and avoiding trouble. To stop and render medical assistance or to pass by injured victims and avoid possible litigation is the ghastly alternative forced on us by the operation of laws pertaining to malpractice. For some doctors, the decision has already been made: they wouldn't touch a highway accident, unless one of their own patients was involved, under any circumstances.

This unfortunate situation was dramatized recently in a television play, and for some time there has been sentiment for the passage of a law in Wisconsin similar to that in California which protects a doctor from liability if he stops to give assistance in good faith. Such a law would permit a doctor to render medical assistance at the scene of an accident or disaster, secure in the knowledge that performance of his duty in a work of compassion and basic humanity would not be subject to legal exploitation because of an unforeseen result or a complication that could not possibly have been anticipated. How much suffering could be eliminated, how many lives could be saved by the passage of a "good samaritan" law can only be guessed.

On the other hand, those who oppose "good samaritan" legislation point out that malpractice suits arising from chance medical treatment are very rare and that for the medical profession to favor such legislation creates the impression that we are trying to protect the incompetent and evade responsibility for our errors, for which we should be liable no matter when we make them.

The frequency of malpractice suits resulting from "good samaritan" service can hardly be accurately determined. In many instances, they might be settled even before they are filed for a so-called nuisance amount. Some insurance companies would prefer to settle a claim rather than go to court and risk the possibility of a sympathetic jury finding for the plaintiff. Because of the nature of accidents—the absence of witnesses for the doctor, the impossibility of follow-up on the part of the doctor, and the patient who may reject the doctor's advice and lie about it later—nobody can be blamed for attempting to escape from a threat of a malpractice suit as cheaply as possible. Few doctors are prepared to take the time from their practice, expose their

reputation to damage and take a chance on a jury of bleeding hearts even when they are completely in the right.

At the same time, "good samaritan" legislation might indeed give the quacks, the incompetents and the negligents a measure of immunity from the consequences of their malpractice. To permit any kind of irresponsible practice of medicine on hapless victims of accidents is unthinkable.

The problem is not simple: the conflicting demands of legal protection for doctors and enforcing responsibility on them offers a medicolegal dilemma. Patients must be protected from unskilled or careless practitioners. At the same time, honest, conscientious doctors must be shielded from speculative lawsuits brought by greedy patients and their lawyers in the hope that someone will settle for nuisance value. Merely to place a limit on the amount that can be collected under the malpractice law does nothing to solve the problem. It is unfair to the patient who genuinely suffers from the incompetent doctor, and does nothing to protect the innocent doctor whose real loss is the time it takes to fight the suit and the damage the imputation of incompetence does to his reputation.

The drafting of proper, effective "good samaritan" legislation will unquestionably require close cooperation between medical organizations and legal organizations. A good beginning would be the establishment of a committee composed of representatives of the State Medical Society and the State Bar Association. The committee would study the problem from all points of view, review existing "good samaritan" legislation in the various states, and perhaps propose a law that will protect both the public and our profession.

"Good samaritan" legislation might possibly be enacted. But if so, it must be public-spirited legislation, based on a realistic approach to the problem, as well as sound judgment and lofty vision.—D. N. G.

The MD's Responsibility to His State Meeting

PECULIAR things are happening in "the house of medicine" today. Bureaucrats in Washington are using IBM techniques to determine what John Jones, M. D. in Spotted Horse can charge for every service he renders patients served, where government funds are wholly or partially employed. Hospitals in many areas are assuming the role of community physician and creating a public image that the fount of medical knowledge and authority rests on Hill-Burton foundations rather than in the office of the individual family physician. And with this ominous change in the structure of medical practice comes an equal and disturbing decline in the role of the county society and the state medical meeting in the important area of postgraduate medical education.

Why is this so, and need it continue to a point where the county society and the state medical meeting join the dodo and the carrier pigeon in oblivion?

At the turn of the century the county medical society was the "doctors' fraternity," and the annual state meeting was an occasion eagerly anticipated as a source of professional knowledge and an opportunity to discuss cases and professional problems with former teachers and colleagues in other cities. Those were the days when professional exchange of experience and avid attendance at lectures provided the best avenue for continued medical education. Medical movies were rarely available, TV wasn't even imagined outside of a few imaginative science writers of the Jules Verne type, and even access to literature was generally confined to the larger communities and those few high and mighty "giants" of the profession who were specialists in the art of surgery.

What a change today! The busy practitioner of 1962 is bombarded with literature; he is swamped with elaborate brochures on a multiplicity of medications and professional aids; he is interrupted in the care of patients by earnest and persistent detail men; his hospital staff demands his presence at frequent meetings; his specialty group or GP unit seeks his attendance at scientific meetings (with bait of credit, or threat of expulsion!) . . . in short, the physician of today is either a nomad from his practice, or he throws up his hands and eliminates all meetings other than three or four each year.

In such a situation many state medical meetings are finding themselves among the

"also rans." They can provide little of the glamour or overwhelming program offerings of an A.M.A. meeting. Nor can they successfully compete with the social pull of the resort conferences (with a chance for a bit of gambling and night-clubbing within the prescribed rules of the Internal Revenue Department!).

And yet, a state medical meeting has something of *special* value to the practitioner which is worth preserving. But it cannot survive if an increasing number of physicians bypass it and restrict their attendance to regional or national meetings of their specialty or area of general practice.

A state meeting . . . YOUR state meeting . . . is the finest "grass roots" medical meeting which can be developed. It's big enough to provide a stimulating program with out-of-state speakers, and to encourage the development and presentation of good scientific exhibits from local hospital staffs or clinic groups. At the same time it's small enough to provide renewed fellowship with former classmates and faculty members to a degree which is lacking in any national or even regional conference.

Why then, is the average state meeting suffering a severe case of attendance malnutrition? In some instances poor program planning may be the answer. Often there is a lack of imagination in providing new modes of presentation. Panels, demonstrations, movies, TV, "wet clinics" . . . all are an important part of a modern-day medical convention, and the program committee which fails to utilize these teaching devices is issuing a blanket invitation to stay away from the meeting itself.

Even the technical exhibits at a well-run medical meeting have educational benefits to be considered. True, a certain proportion of physicians regard the technical exhibits as "commercialization" of the scientific program, and hesitate to taint themselves by stopping at any of the booths. However, there are many more physicians from smaller communities or in rural practice who welcome the opportunity to see what new drugs and appliances are being offered, without the pressure of a full waiting room of patients.

No medical meeting exhibit should be continued solely on the basis of financial support of the scientific program itself. No one should ask the physician to "sell his soul", just to support a commercial exhibit. The day of the "hard sell" among exhibitors at medical meetings is a thing of the past. A few companies still emphasize direct sales at medical conferences, and their representatives are a bit on the overeager side. But most of the ethical houses conduct their physician contacts in keeping with the professional standards of those in attendance.

The educational aspects of the modern-day medical exhibit should not be overlooked or derided by the purist MD who scornfully brands all displays as "technical prostitution." He is possibly unaware of the fact that most of the scientific exhibits he admires and studies are largely supported by funds from the commercial houses. He accepts the lectures and demonstrations on the scientific program itself with little recognition that without exhibit support he would be asked to pay a registration fee of $25 to $50.

Those who view medical meetings, from the hospital staff level right up to the summer meeting of the A.M.A., are concerned that in some areas physicians are failing to appreciate the importance and unique qualities of their state meeting. By their failure to actively support their meeting on a state level they are threatening the demise of a meeting which has much to offer in terms of close professional fellowship and keeping the quality of medical practice in the immediate area alert to new developments as they relate to individual practice.

The public is prone to criticize the medical profession for its alleged major concern with the financial returns of their practice. Attendance at medical meetings represents a loss of income which is often overlooked by patients. It is important that annually your patients either read this legend on your office door: "To My Patients: I am Attending My State Medical Meeting so I Can Better Serve You. Please call Doctor _____ in My Absence," or your office girl should be asked to explain your absence in a similar manner.

Your state meeting is worthy of your support . . . and it can only remain a vital factor in the life of your state if you attend and take an active role in all aspects of the meeting.

THE MEDICAL FORUM

Urge Members to Attend House of Delegates Sessions May 7, 8, 9 During Annual Meeting

The 1962 annual session of the House of Delegates of the State Medical Society will be held at the Milwaukee auditorium Monday, May 7, to Wednesday, May 9.

All members of the State Medical Society are invited to attend the sessions of the House and its reference committees where the resolutions, reports and other business of the Society will be discussed during the three-day session.

All sessions of the House of Delegates will be held at Juneau Hall in the Milwaukee auditorium. The first session of the House will be held at 7:00 p.m. Monday, May 7. At this time all reports of officers and committees and resolutions will be received. The nominating committee will also be selected at this session.

Meetings of the reference committees will be held starting at 9:00 a.m. Tuesday, May 8, at the auditorium.

Dr. L. H. Lokvam, Kenosha, president of the Society, points out that "it is a privilege as well as an opportunity for any interested member of the Society to appear before these committees and present his views on any matter properly before them."

Doctor Lokvam added that it is the prime purpose of the House of Delegates to establish policies for the State Society through free discussion that represents the will and wishes of membership.

He pointed out that delegates and others officially associated with the House of Delegates normally are the only persons to participate in the proceedings of the House of Delegates. Any member of the Society who is not a member of the House may address the House of Delegates on any pertinent subject. This is accomplished by permission of the Speaker of the House of Delegates with consent of the House.

The second session of the House of Delegates will be held at 7:30 p.m. on Tuesday, May 8, at Juneau Hall. This session is normally devoted to receiving the reports of the reference committees and any last-minute business to come before the House.

The third and final session of the House is scheduled for 9:00 a.m. Wednesday, May 9. This session is held to elect officers and receive any final reports. Copies of committee reports and resolutions have been sent to all State Medical Society councilors and officers, to county medical society presidents and secretaries, and to the delegates and alternate delegates of county societies.

BROWN COUNTY SOCIETY STATES VIEWS ON HEALTH CARE OF AGED

The physicians of the Brown County Medical Society recently expressed their concern about proposals to place health care of the aged under Social Security.

In a letter to area newspapers, the Society stated:

"The Kerr-Mills Bill seems to us to be a better and more practical means of handling the situation and we urge that it at least be allowed to demonstrate what it can do. In our experience, older people pay their hospital and doctor bills more promptly and more reliably than many young married couples with small children.

"We feel that medical care needs and medical care expenses are not exclusively a problem for those over 65. Those who need help should have it regardless of their age—those over 65 should not have their bills paid by taxing the younger workers.

"The Social Security approach will not decrease the cost—it will simply shift it to other shoulders and add the burden of countless clerical workers to do a job already being done in a manner envied by the rest of the world."

ANNUAL DINNER PROGRAM SET

The Annual Dinner of the State Medical Society, to be held Wednesday evening, May 9, in Milwaukee, will feature musical entertainment, dancing, presentation of certificates to new Fifty Year Club members, and installation of Dr. Nels *Hill*, Madison, as president of the society.

The dinner will be held at the Hotel Schroeder, following the president's reception.

Offering the musical entertainment will be the Marquette University Glee Club and Grant Krueger and "The Executives." Vocalists with the orchestra are Marvin Moran and the *Malone Sisters*.

Reservations may be made at the registration desk in the Auditorium for those who have not previously made them.

Insurance Associations Express Views on Two Health Care Programs for Senior Citizens

AMA and Blue Shield
AHA and Blue Cross

Widespread interest has occasioned the recent announcements by the American Hospital Association and Blue Cross of a health care program for persons age 65 and over. Similar interest has accompanied an announcement by the American Medical Association and the National Association of Blue Shield Plans of a nationwide Blue Shield plan for senior citizens.

The *Wisconsin Medical Journal* reprints in full on these pages an article from the February, 1961, issue of *Health Insurance Review* expressing the reactions of several health and life insurance associations to these two programs.

* * *

The Health Insurance Association of America, the American Life Convention, and the Life Insurance Association of America have jointly opposed the American Hospital Association's proposed health care program for the aged, announced early in January, which calls for a new federal subsidy.

Walter J. McNerney, president, Blue Cross Association, presented the proposed program at a joint meeting of the American Hospital Association and the Blue Cross Association on January 3. It would provide uniform benefits and rates for all persons 65 and over. It would be financed by government funds for those whose income would be below a level to be designated, also by premiums of $10 to $12 a month from subscribers with income above that level. It would provide 70 days of hospital care and would be administered by Blue Cross. Mr. McNerney described the program as more liberal than the Administration's King-Anderson bill.

AHA Proposal "Unnecessary"

The company associations, in their opposition to the program, stated that the AHA proposal of a new federal subsidy is as fundamentally objectionable as the King-Anderson bill, because it, too, is unnecessary. "Of equal importance, it would provide the proposed additional benefits under the administration of a single insurance organization, the Blue Cross. We regret that the proposal would thus tend toward a self-serving insurance monopoly financed with federal funds, which manifestly would not be in the public interest."

The statement of the company associations also brought out that: (1) Monopoly in any form tends to stifle experimentation in the expansion and improvement of any product or service, including health insurance. (2) The health care needs of the aged can be adequately met through a combination of voluntary insurance and the benefits provided to the medically indigent by the Kerr-Mills act and the states. (3) The insurance business continues to support the voluntary system of health care and its financing as the best possible approach in meeting the health care needs of the public, especially those of the aged whose growing numbers attest to the success of that system. (4) The insurance business pledges its continued efforts to improve its coverages in pace with the advances in medical science and to make such coverages available to all persons at the lowest possible cost.

The American Hospital Association had stated that, under the proposed Blue Cross program, eligibility for government aid would be based on income and the determinations made under public welfare programs.

AHA's Statement of Policy

At the same time the American Hospital Association's House of Delegates, in a six-point statement of policy on the financing of health care needs for the aged:

(1) Reaffirmed the need to continue vigorous efforts to foster programs in all states for adequate health protection of the indigent aged, under a mechanism similar to the Kerr-Mills act. (2) Recommended the earliest possible implementation of a national Blue Cross program for a voluntary nonprofit plan available to all persons 65 and over. (3) Recognized that government assistance to many retired persons is necesary to implement this national proposal. (4) Stated that aged persons should receive governmental financial aid on a decreasing scale related to income. (5) Emphasized the urgency and importance of planning for the providing of facilities and personnel to render high quality care to the aged. (6) Declared that the best interests of the retired aged will not be served by passage of the King-Anderson bill, and stated the belief that they would be better served by a program such as proposed by Blue Cross.

BLUE SHIELD PLAN

The American Medical Association and the National Association of Blue Shield Plans on January 17 announced their joint answer to possible socialized medicine for persons of 65 and over, to prove that medical care expenses for the aged can more properly be met under auspices of private incentive than under a government-financed program.

The Blue Shield program requires approval of each of the 69 Blue Shield plans in the U.S., but John W. Castellucci, executive vice-president of the Blue Shield association, has stated that he hoped the program could be advertised in April so it could be inaugurated in July. The AMA's board of trustees has recommended that state medical societies cooperate with Blue Shield plans in adopting the program.

Cost: About $3 a Month

The program will pay the full cost of service for couples with an annual income of $4,000 or less and single persons with incomes of $2,500 or less. Doctors may charge others more than the schedule if they wish. The cost of the program, however, will be uniform—about $3 a month for each person. Fees payable by Blue Cross to physicians would vary according to the community patterns of cost.

The program will pay for surgery in a hospital or the physician's office. It will cover medical care in a hospital or nursing home, but the number of visits—at least 30—was not announced. Payments will be provided for anesthesia, X-rays, laboratory tests, radiation treatments, and pathology services.

The success of the program, stated Dr. Henry S. Blake, chairman of the board of directors, National Association of Blue Shield Plans, will depend upon three essential elements: "It must be uniform in scope of benefits, uniform in cost, and it must have the solid support of the medical profession."

Museum of Medical Progress Opens May 1

The Museum of Medical Progress at Prairie du Chien will open May 1 for its second full season of operation. Some 20,000 persons are expected to view the exhibits during the coming season.

Several new features will be evident. The major one is a large exhibit on diagnosis. In a series of panels and cases, the display traces the development of various diagnostic instruments and shows the viewer what the physician sees when he looks inside the body.

Included are sections on the gastroscope, otoscope, ophthalmoscope, microscope, x-ray and stethoscope. The final section, dealing with the stethoscope and heart, allows the visitor to hear actual heart sounds and see them visually presented on an electronic scope.

The new exhibit was developed by the State Medical Society and constructed in cooperation with the Wisconsin Heart Association.

Other improvements include new presentations of the eras of the doctor on horseback and horse and buggy doctor. A reproduction of a physician's office in Civil War days has been added.

In addition, the presentation of military medicine has been revised for the coming season.

The museum, a project of the Charitable, Educational and Scientific Foundation, is open daily from May through October. Visitors this year may purchase a combination ticket, at reduced price, to visit both the Museum of Medical Progress and Villa Louis in Prairie du Chien. The State Historical Society of Wisconsin operates both sites.

Another interesting feature of the museum this year will be a series of changing exhibits through the months it is open. During May, an exhibit titled "Life Begins" will be on display. It shows the development of the fetus from conception to birth in a manner understandable to the general public.

Other equally interesting exhibits will be featured during the coming months, including a cancer display with live laboratory mice with various stages of induced cancer and a large display on space age medicine.

WPS Passes Fifty Million Mark; Commission to Report to House

Contract benefits paid by Wisconsin Physicians Service (WPS) since its inception in 1946 have passed the Fifty Million Dollar mark in 1961.

This is one of several achievements noted by the Commission on Medical Care Plans of the State Medical Society in its report to the House of Delegates on operations of the WPS—Blue Shield Plan for 1961.

The exact figure for total claims payments for 1946 through December 31, 1961, was $51,877,158.

As of the end of the year, the Commission on Medical Care Plans reported that WPS had in force 99,000 surgical-medical contracts, 44,000 hospital contracts, and 17,000 major illness contracts for a total of 160,000 contracts.

In comparing the activity of WPS in 1961 with previous years, the report points out that in 1957 WPS earned premiums totaled $5,308,167. During 1961 earned premiums rose to a new high of $9,707,643.

Administrative expense, the ratio of expenses incurred to premiums earned, has been substantially reduced during the past five years. In 1957 the administrative expense totaled 17.58 per cent of premiums earned. In 1961 the expense ratio was 11.63 per cent.

Total reserves, frequently referred to as "surplus," have seen substantial improvement in WPS since early 1960. On March 31, 1960, total reserves of WPS were $1,007,292. On December 31, 1961, reserves totaled $2,016,752. The Commission reported that "the continued stabilization of surgical-medical loss ratio and the sharp reduction in the hospital benefits loss ratio contributed heavily to this healthy financial result."

The Commission reports that among the major 1962 goals of WPS are the expansion of enrollment especially in surgical-medical coverage, increased sale of Century Plan for persons over age 65, and up-grading coverage from B to A for the scheduled contract holders and A to Special Service for others. Major illness coverage will also receive increased attention.

The Commission also reports that activation of Wisconsin's 32nd Division in late 1961 produced a sizeable increase in the payment of benefits under Medicare. The surgical-medical portion of Medicare handled by the State Medical Society involved the processing of almost 6,000 claims totaling more than $400,000 in benefits in 1961.

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County Society Presidents and Secretaries Learn About American Medical Association

More than 60 physicians attended the Annual County Medical Societies Presidents and Secretaries Conference held March 16 at the American Medical Association headquarters in Chicago.

Purpose of the conference this year was to gain information on the numerous activities of the AMA.

"Many physicians tend to think of the AMA in reference to the King-Anderson Bill or other legislation," said Dr. Ernest B. *Howard*, assistant executive vice-president. He then went on to list 19 major councils and committees of the AMA which do important work in areas other than the socio-economic field.

The four major functions of the American Medical Association, as listed by Doctor Howard, are:

Education of physicians
Health education for the public
Services for physicians
Relationships with government

He stated that there are 752 physicians who devote time to official participation in AMA activities, as officers or in committee work. Adding 5,400 who participate in activities at the state society level and 40,500 at the county society level, it makes a significant number of physicians in this country who have a direct voice in their medical organizations.

The presidents and secretaries heard capsule reports on the activities of the divisions of scientific activities, environmental medicine, communications, and legal and socio-economic activities of the AMA.

Each of these divisions is further broken down into special areas to accomplish one or more of the aims outlined by Doctor Howard.

Making the presentations were Dr. Walter S. Wiggins, Dr. Raymond L. White, C. Joseph Stetler and James Reed.

Main speaker at the event was Congressman Durward G. *Hall* of Missouri. Doctor Hall, one of the seven physicians in Congress, is presently serving his first term.

"There is a desperate and urgent need for participation in the mechanics of good government," Doctor Hall told the Wisconsin physicians. "Be interested in everything —think of good government as a whole, not just medicine."

"The one thing that will destroy civilization is for the wrong people to try to change it and the right people not to try," he added.

On the specific issue of health care for the aged, he said, "We've been whiplashed into believing that the only way our elder citizens can survive is under the administration's medical care plan under social security."

Recommending specific action, he told the Wisconsin physicians to:

1. Write their congressmen and senators. "Make no mistake about it, congressmen are sensitive to letters, especially the second and third."
2. Form a Healing Practices Committee to give nonpartisan support to candidates who agree with your philosophy. "If your congressman shares your viewpoint, he deserves this kind of support. If he's on the fence, he cannot ignore your support."

Such a Healing Practices Committee would include physicians, nurses, veterinarians, pharmacists, dentists and others interested in health care, according to Congressman Hall.

REGISTERING AT THE CONFERENCE are, left to right: Dr. A. P. Schoenenberger, Madison; Dr. Charles Behnke, Oshkosh; Dr. H. J. Laney, Prescott; Robert Dawson, Eau Claire, regional representative for the State Medical Society of Wisconsin; and Dr. John W. Rupel, Marshfield. Twenty-five county societies were represented at the conference.

Concerning the King-Anderson Bill, he said, "It's later than you think, but it isn't past the point of no return."

James Foristel, director of the AMA's Washington office, had more specific statements about the proposed legislation: "Can we win if our measure comes to the House floor? I think so at the present time."

However, he added that it would depend upon many unpredictable factors at that specific time.

"Your whole job," he told the presidents and secretaries, "is the member of Congress from your own district and your two senators."

The county society officers toured the AMA headquarters during the noon hour to receive specific information on AMA activities and operations.

A.M.A. ANNUAL MEETING IN CHICAGO

Wisconsin physicians will have an excellent opportunity to attend the annual meeting of the American Medical Association this year. It is being held in Chicago June 24–28.

"Medicine in the Atomic Age" will be the theme of the scientific program. All sessions and exhibits will be in Chicago's giant new auditorium and convention hall, McCormick Place.

Medical Profession Must Keep Abreast of Rapid Expansion in Health Care Programs

Commission on State Departments Report

The Commission on State Departments has submitted annual reports for its 10 divisions to the House of Delegates reviewing the activities of the past year and making recommendations for action by the delegates.

Introducing the individual reports, the Commission had this to say about state agencies rendering health services:

> "They are expanding with considerable rapidity; and it appears that a fully realistic appraisal is needed so that the medical profession may keep abreast of current programs, in advance of current trends and in a position of leadership for the health of the public."

With this goal in mind, the Commission recommended a thorough analysis of the administrative codes of the many state agencies and departments whose activities touch on health care of the people of Wisconsin.

"This action will enable the Society to obtain a much needed view of the whole health care picture in government, and to chart a course of greatest assistance to the health of the public," the Commission concluded.

NEW DIVISION MEMBERS NAMED BY COMMISSION ON STATE DEPARTMENTS

Four physicians have been named to membership in divisions of the Commission on State Departments.

Dr. Walter J. Urben, Madison, has been appointed to membership on the Division on Nervous and Mental Diseases.

Dr. Milton Trautmann, Prairie du Sac, and Dr. George Anderson, Stevens Point, have been reappointed to the Division on Safe Transportation.

Dr. Horace K. Tenney, III, Madison, has been appointed to the Division on School Health.

Each of the physicians was named to a three-year term.

AGING

The Division on Aging reported preliminary planning for a Conference on Medical Aspects of Caring for the Aging Patient and a possible Wisconsin Conference on Home Care.

"County medical societies should continue to take a leading role in developing community understanding of the problems and opportunities for elderly citizens," the Division stated, recommending the following AMA guides for use by local society committees on aging:

1. "How the Older Person Can Get the Most Out of Living"
2. "Ways in Which Younger and Older Adults Can Improve and Maintain Their Health"
3. "Education of Children for the New Era of Aging"
4. "A.M.A. Position on Employment of Older People"

News Briefs

NATIONAL HOSPITAL WEEK

National Hospital Week, May 6–12, will be marked by hospitals and the medical profession across the country.

Commenting on the occasion, Dr. Edwin L. Crosby, director of the American Hospital Association, said that present day hospital care represents a unique combination of science and individual attention.

He pointed out that "with more than 25 million admissions to American hospitals each year, one of every eight persons benefits from the hospitals' uniting of scientific progress and human concern."

CHEST DISEASES

Two major items of interest to the Division on Chest Diseases during 1961 were the hypertension screening program of the State Board of Health and a study of the care of tuberculous patients in Wisconsin.

On the former, the Division reported that an eight-county study revealed 447 cases of previously unsuspected heart diseases.

"The Division feels these findings have significance and suggest value in the program," the report states. It will continue to evaluate this pilot study.

The State Board of Health is planning an exhaustive survey of the merits of county vs. state centralized TB care in Wisconsin, and the Society will be asked to participate. In view of this the Division deferred action on a request from the 1961 House of Delegates on the subject.

HANDICAPPED CHILDREN

During 1960, 26 orthopedic clinics were held at 14 centers in Wisconsin at the request of the county medical societies involved. The Division on Handicapped Children reports that with the growing number of full-time orthopedists in Wisconsin, the overall need for the orthopedic clinic program is changing. As a result, the orthopedic clinics have been eliminated in Brown, Fond du Lac and Outagamie counties.

(Continued on page 260)

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Commission Reports to Delegates

(Continued from page 259)

Currently about 1,200 children are receiving Bicillin through a program operated by the Bureau for Handicapped Children of the Department of Public Instruction. Revisions in the procedures under which a patient may qualify for the program have been made as requested by the House of Delegates in 1961.

MATERNAL AND CHILD WELFARE

The Maternal Mortality Survey is in its seventh year of operation according to the Division on Maternal and Child Welfare. The Division reports that it continues to produce valuable information which is transmitted to physicians and hospitals in a variety of ways.

The Division reemphasizes that medical staffs of hospitals should develop rules requiring that a physician be in attendance at the time an oxytocic is administered, and "he should either be in direct attendance of the patient until after delivery or be in such close proximity to the patient that he can be reached and provide attention to the patient within a few minutes after an obstetrical emergency arises."

The Division regards the Maternal Mortality Survey as one which highlights special problems to "assist many physicians in meeting obstetrical emergencies in an increasingly effective manner."

With regard to infant deaths, the Division regards infant deaths (children under one year of age) as a continuing matter of concern. Reports from the State Board of Health indicate that Wisconsin's experience (23.4 infant deaths per 1,000 live births) is somewhat better than the national average (25.7 per 1,000 live births) in 1959.

The Division reports the chief causes of infant death in Wisconsin are prematurity, birth injuries, atelectasis and asphyxia, congenital malfunctions and pneumonia. The Division urges hospital staffs to make infant deaths a subject of continuing study.

Special attention is also being given by the Division to medical and nursing problems associated with prematurity. Seven conferences were held on this subject during 1961, and these meetings emphasized the "team approach" to premature care.

NERVOUS AND MENTAL DISEASES

The Division on Nervous and Mental Diseases reports a continuing study in cooperation with the State Mental Health Advisory Committee to analyze the commitment laws of Wisconsin. The Division also has under study the complex matter of policies relating to the commitment and release of the insane.

The Division is also in the midst of several studies relating to driver licensing problems concerning persons released from mental institutions.

PUBLIC ASSISTANCE

The Division on Public Assistance is supporting efforts to implement the Kerr-Mills Act in Wisconsin. In addition it continues to observe the operation of health care provisions of the State's public assistance laws and encourages close liaison by county medical societies with local public welfare departments as a means of assuring effective programs in this field.

REHABILITATION

The Division on Rehabilitation maintains liaison with the Department of Vocational and Adult Education and its Rehabilitation Division. During the past year, it has actively supported the Governor's Committee on the Employment of the Physically Handicapped.

SAFE TRANSPORTATION

The third phase of an Automotive Crash Injury Research program in Wisconsin will begin July 1, 1962, according to the Division on Safe Transportation. This portion of the survey will include reporting of accidents on automobiles five years old or less involved in an accident where there is death or injury. These studies will involve only those accidents investigated by an officer of the Wisconsin State Highway Patrol. The cooperation of physicians in providing reports of injury will be appreciated.

Since the adoption by the 1961 Legislature of the nation's first law requiring installation of front seat belts in 1962 or later model automobiles, the Division on Safe Transportation has concentrated its efforts on encouraging automobile owners to utilize the seat belt. Extensive public informational efforts have been undertaken and will continue.

SCHOOL HEALTH

The Division on School Health recommends that the State Medical Society urge colleges and universities in Wisconsin to provide more extensive health education to students preparing for careers in teaching.

In addition, the Division recommends that county medical societies make available panels of speakers to assist school administrators in dealing with programs and projects on school health. It also encourages meetings on the community level between physicians and school administrators to discuss common problems in the health and fitness of school age children.

School health administrators in Wisconsin are urged to develop modified physical education programs so that no student able to attend school need be excused from physical education. The Division recommends, however, that the extent of physical activity desirable for any student continue to be a matter for recommendation by the student's personal physician.

VISUAL AND HEARING DEFECTS

The Division on Visual and Hearing Defects has met with representatives of the Industrial Commission for review of methods of determining impairment of eye, ear, nose and throat and related structures. The Industrial Commission at the present time utilizes the recommendations of the AMA for determination of hearing impairment. The Commission and the Division continue to explore the advisability of utilizing the recommendations of the AMA for determination of visual impairment. Subsequent meetings will be held with representatives of the Industrial Commission along these lines.

HEARING ABOUT THE AMA are, left to right: Dr. F. L. Weston, Madison; Dr. S. H. Ambrose, Whitewater; Jack Blaine, staff member of the State Medical Society; Dr. D. N. Goldstein, Kenosha; and Dr. Roman E. Galasinski, Milwaukee. The physicians were attending the Annual County Medical Societies Presidents and Secretaries Conference in Chicago March 16.

Hypnosis, Seat Belts, Venereal Disease Resolutions to House

Seven resolutions have been submitted for action to the House of Delegates at the State Medical Society annual meeting May 7–10 in Milwaukee.

Five were introduced by the Commission on State Departments, one by the Editorial Board, and one by the Section on General Practice.

The resolutions ask the House of Delegates to:

1. Assist the American Medical Association in control of the nonmedical use of hypnosis by:

   a. Providing an authoritative statement for the public which state and county medical societies could distribute in their own communities.
   b. Undertake special efforts with the National Education Association to explain the dangers of hypnotism for entertainment purposes in their joint and separate communications to physicians, teachers and school administrators.
   c. Establish appropriate medical advisory services to "booking" services for school assembly programs to assure accuracy and reliability on topics involving or affecting the health of school students and personnel.
   d. Urge all state and county medical societies to cooperate in the educational effort outlined above.

2. Advocate the use of automobile seat belts and urge every physician in Wisconsin to use seat belts in personal automobiles, and that members of the House and Council and officers of the State Medical Society set the example by using seat belts in their own automobiles.

3. Suggest to the American Medical Association that it focus attention on health education and practices affecting school age citizens through development of a special school health issue of *Today's Health*. Also, pledge the support of the State Medical Society of Wisconsin to assure the widest possible promotion and distribution of such a special issue.

4. Urge the State Board of Health to develop and distribute to the medical profession a simplified summary of the rules for reporting venereal disease, with indications of the newer methods of therapy and management.

Request the appropriate committee of the Society to work with the State Board of Health in development of an effective informational program for the profession.

When this information is made available, each county medical society and hospital medical staff be requested to officially bring the subject of venereal disease reporting before its members for discussion.

5. Encourage component county societies and local physicians to participate in sports injury prevention and control programs in as many high schools as possible and appoint interested physicians as team physicians.

Physicians who serve as team physicians be encouraged to do so for a full season in a particular sport, or for a full school year.

That team physicians be encouraged to attend all scheduled competitive events and that school officials assure him a place on the bench, or in close proximity to it, so that he may more readily observe the occurrence of injury and provide aid more promptly.

6. Commend R. S. Baldwin, M.D., Marshfield, for 12 years of devoted service to the *Wisconsin Medical Journal* and members of the society as medical editor. Doctor Baldwin retired from the post this year.

7. Commend the American Medical Association for its forthright statement of ethical principles relating to physicians assisting other physicians in the performance of surgery.

Also, urge all specialty organizations in Wisconsin to attempt solutions of ethical and economic problems affecting all physicians through proper medical channels.

The resolutions will be submitted to the House on Monday, May 7, discussed before reference committees on Tuesday morning, May 8, and receive final action that evening.

D.A.R. OPPOSES FEDERAL AID

The Wisconsin Society of the Daughters of American Revolution recently reaffirmed its opposition to a federal medical aid program tied to Social Security.

The action was taken at its annual meeting in Milwaukee on March 15.

Ask Support for Medical Self-Help Training

The support and cooperation of all county medical societies and the membership of the State Medical Society has been requested for the medical self-help training program to teach at least one member of each family in Wisconsin how to survive a national emergency and how to meet their own health needs if deprived of a physician's services.

This program, developed by the Public Health Service in cooperation with the AMA, has been endorsed by the Council of the State Medical Society.

The appeal for support and cooperation of physicians and county societies has been made in a report of the Committee on Disaster Medical Care to the House of Delegates for consideration in May.

In Wisconsin the program is already under way.

Representatives of the State Bureau of Civil Defense, State Board of Health, State Medical Society and State Department of Public Instruction form an executive committee which advises the Bureau of Civil Defense on the conduct of the program in Wisconsin.

The State Board of Vocational and Adult Education and the University of Wisconsin Cooperative Agricultural Extension Service serve as participating agencies. The State Board of Health will administer the program.

For its part, the State Medical Society has agreed to provide support and professional medical advice to the State Board of Health in administering the program; encourage county medical societies, county civil defense medical directors and individual physicians to provide guidance, professional leadership and participation as instructors for locally presented courses; and to actively promote the program.

Courses are currently being initiated in 75 areas of the state. Training kits have been allocated to selected vocational schools, county home demonstration agents, county civil defense directors, and local full-time city and county health departments. They, in turn, will arrange the conduct of local instructional courses. Organizations and groups interested in taking the eight, two-hour sessions should contact these agencies.

The Committee on Disaster Medical Care directs the attention of county medical societies to the following statement of policy:

> ". . . The practicing physician . . . will be asked to provide the professional leadership so necessary for the successful teaching of the general population. To assist him and to do the actual instruction in most cases, the wholehearted support of the allied health worker and individuals with previous experience in this type of teaching is necessary.
>
> "Whenever possible, however, it is highly desirable that each course be taught under the supervision and guidance of the physician if other than a physician serves as an instructor."

The Committee points out that since this is not first aid, but rather medical self-help, it is extremely important that the medical profession accept this responsibility in each community.

Medical Assistants to Meet June 1-3 at Sturgeon Bay

Medical assistants throughout Wisconsin will gather at the Eighth Annual Meeting of the Wisconsin State Medical Assistants Society to be held at Leathem Smith Lodge in Sturgeon Bay June 1, 2 and 3.

Among the subjects to be discussed at the meeting are: Hematology in the Doctor's Office, Progress in Medical Care, Criminal Pathology, Communism in Africa, Everyday Problems of the Medical Assistant, Sterilization Procedures for the Medical Office, and Affairs of the American Association of Medical Assistants.

Anyone interested in obtaining a program may write to Miss Sigrid **Muehlhauser**, Convention Chairman, c/o John O. **Muehlhauser**, M.D., 368 Louisiana Street, Sturgeon Bay, Wisconsin.

One of the highlight speakers at the meeting will be Miss Alice **Budny**, Milwaukee, national president-elect of the American Association of Medical Assistants.

TRINITY HOSPITAL AT CUDAHY SETS CLINIC DAY FOR MAY 12

With the hope of establishing an annual event, Trinity Memorial Hospital, Cudahy, will hold a Clinic Day May 12 from 9 a.m. to 1 p.m. at the Red Carpet Inn, 4747 South Howell Avenue, Cudahy. The meeting has been approved by the American Academy of General Practice for four hours of Category I credit for members of the AAGP who attend.

Guest speakers will include Dr. Bernard **Lown**, cardiologist, assistant professor of medicine, Harvard School of Public Health, and junior associate in medicine, Peter Bent Brigham Hospital; Dr. Dwight E. **Harken**, associate clinical professor of surgery, Harvard Medical School, and chief of thoracic surgery, Peter Bent Brigham Hospital and Mount Auburn Hospital; and Drs. Robert A. **Frisch**, Howard L. **Correll** and Raymond L. **Lange**, all of the Marquette University School of Medicine. Dr. Jacob M. **Fine**, chief of medicine at Trinity Memorial Hospital, will moderate a question and answer period. Dr. George V. **Murphy**, chief of staff, and Dr. J. S. **Hirschboeck**, dean, Marquette University School of Medicine, also will participate in the program.

Waukesha Society to Start Special Plan to Immunize Adults

The Waukesha County Medical Society has announced a special program to immunize adults against tetanus, typhoid fever, paratyphoid and smallpox.

Adults will make arrangements with their own physician for the immunization. A standard fee of $1 per immunization will be charged by all participating physicians.

The program began in early April and will extend for six weeks.

The Medical Society noted that many persons have been immunized as children but in the intervening years protection from the vaccine may have worn off.

Minutes of Council Meeting

Chicago, Illinois, November 18–19, 1961

1. Call to Order and Roll Call

The Council was called to order by Chairman Fox at headquarters of the American Medical Association in Chicago at 2:00 p.m. on Saturday, November 18, 1961.

Councilors and Officers present were Doctors James, Schulz, Nordby, J. H. Houghton, Dessloch, Blanchard, Kief, Fox, Mason, Frank, Ekblad, Egan, W. J. Houghton, Willson, Curran (Saturday only), Sorenson, Lokvam, Hill, Callan, Simenstad, Bernhart (Saturday only), Galasinski, Collentine, and Stovall. Staff and consultants present were Messrs. Crownhart, Thayer, Murphy and Toser; Mrs. Anderson; Misses Rendall and Pyre. Members of the staff of the American Medical Association other than those participating in the program: T. A. Hendricks, Leo Brown, and Charles Johnson.

2. The American Medical Association

Saturday afternoon was devoted to a presentation by its executive staff of the following program, including a building tour:

American Medical Association Organization, Structure and Program
F. J. L. Blasingame, M. D., Executive Vice President
Campaign Re King Bill
E. B. Howard, M. D., Assistant Executive Vice President
Field Service Activities
Aubrey Gates, Director, Division of Field Service
Communications—Press—Radio—TV—Magazines—AMA News—Today's Health—James Reed, Director, Communications Division
Socio-Economic Activities
Economic Research—Leonard Martin
State Legislation—Oliver Neibel
Dictionary of Disease
Burgess Gordon, M.D., Standard Nomenclature Department
Scientific Activities
John Youmans, M. D., Director
Environmental Medicine
Raymond L. White, M. D., Director

After a question and answer period, the Council recessed at 5:15 p.m. until Sunday, November 19, at 9:25 a.m.

3. Minutes of July Council Meeting

On motion of Doctors Willson–Egan, carried, minutes of the July 28–29, 1961, meeting were approved.

4. Congress on Medical Quackery

Mr. Thayer presented a comprehensive report, with tape recordings and slides, of this national conference attended by himself and Doctors Robert Zach, Monroe, and Robert Samp, Madison. The following recommendations were incorporated in the report, i.e., that

a. the State Medical Society sponsor a Wisconsin Conference on Quackery in cooperation with the State Board of Medical Examiners, State Board of Health and law enforcement agencies, with participation by legislators, pharmacy, nursing, hospitals, and voluntary organizations;
b. the possibility of a Cancer Quackery Law be investigated in Wisconsin, prohibiting chiropractic cancer treatment;
c. lectures on chiropractic be given in the medical schools and even in pre-med courses;
d. basic science reciprocity requirements be studied;
e. the State Board of Medical Examiners be given more investigative help;
f. consultation be had with the Food and Drug Administration for an exchange of ideas;
g. American Cancer Society proposal to utilize volunteers throughout Wisconsin to report quasi-medical practices be encouraged;
h. a thorough review of all Wisconsin laws and official activities relating to the control of quackery be conducted;
i. portable exhibits on quackery be made available if possible to county medical societies through the Charitable, Educational and Scientific Foundation of the State Medical Society and its Museum on Medical Progress;
j. withdrawal of Veterans Administration approval of chiropractic schools for veterans training be sought.

On motion of Doctors Egan–Nordby, carried, the report was adopted with the request that a copy be sent to the Council.

5. Report of Planning Committee

a. Chiropractic Research

Doctor Frank presented the following report with respect to administrative rules which the State Board of Examiners in Chiropractic proposed to adopt on "Chiropractic Research":

"The October 1961 issue of the *Wisconsin Administrative Register*, published by the state, contained proposed rules drafted for the State Board of Examiners in Chiropractic. These will automatically become part of the administrative code of that Board unless someone requests a hearing by December 1, 1961.

"The proposed rules of the Board would encourage the establishment of non-stock, non-profit research corporations to conduct chiropractic research. The State Board of Chiropractic would control, under the proposed rules, all chiropractic research conducted through such corporations, which involves human beings.

"The board would have substantial supervisory authority over research corporations and their research projects. It can disapprove any research

project when in its judgment significant progress is lacking. Further, the board would have the power to demand copies of all records pertaining to any research.

"Chiropractic research has been in the news several times this year. Most of you remember the black box produced by members of the Toftness Chiropractic Clinic of Cumberland and condemned by the federal Pure Food and Drug Administration several years ago. A federal court ruled that the machine was worthless and banned its sale. Its successor, a research model, its color now changed to gray, has been the subject of controversy this year, first, in the hearing on the chiropractic bill for recognition under the Workmen's Compensation Law and twice since then in hearings relative to the reappointment of one Merlin Groskopp of Clear Lake to the state chiropractic board. While it is asserted by some that those proposed rules are aimed at the new research model of the Toftness machine, the rules are so broadly and vaguely drafted that it might equally be asserted that their use could be encouraged through a sympathetic state board.

"The whole effort smacks of an attempt to lend an air of respectability and validity to a scheme which, without regard to its economic implications, is clearly without scientific foundation. The corollary is that these rules could, by design or otherwise, furnish a shelter of respectability for useless and even dangerous experiments on human beings, in the name of research *licensed and authorized by the State of Wisconsin.*

"The attorneys for the State Medical Society advise first, that they find no authority in the Wisconsin Statutes for the chiropractic board to propose, much less adopt or enforce such rules; and second, that if such authority existed in the board, the proposed rules would need very substantial revision for the protection of those people who would permit themselves to be the objects of chiropractic research. They also note that while under the proposed rules any machine employed in chiropractic research are to be used *only* for research purposes and not for diagnosis or therapy, the users themselves admit that they do not know what the machine does, or where the research is leading them. The attorneys emphasize that it is, therefore, not practical to expect the practitioners, who will be the researchers, to distinguish research from diagnosis from therapy.

"The Planning Committee thinks the proposed rules present an underlying issue of substantial importance, namely, the public policy and scientific desirability of having any purely licensing body seek to control the research efforts of autonomous corporations. There is no question of the importance of safeguarding the public health and the public interest generally, but your committee suggests that this can be better accomplished through organizations other than bodies whose sole authority is to license individuals.

"The Planning Committee recommends that the Council authorize the State Medical Society to request that the Chiropractic Board conduct a hearing on the proposed rules and that it oppose the rules at such hearing on the two grounds suggested above. It is the conviction of the Planning Committee that the medical profession has the responsibility of emphasing through appropriate means the absurdity and at the same time the dangers to the public which could follow the adoption of these rules."

On motion of Doctors Willson–James, carried, the Council voted to adopt the report and execute the recommendation.

b. Medical Education

There was discussion of this problem in Wisconsin and the Planning Committee, on motion of Doctors Egan–Schulz, carried, was authorized to proceed with various studies.

c. Interprofessional Conferences

The following report was made by the Planning Committee, no action requested of the Council:

One of these was held some years ago, and while considered quite successful, has not been repeated. The Planning Committee believes that these should be held every two years in the interest of the maximum of interprofessional harmony and understanding.

In alternate years, a health legislative "round-up" should be instituted, very possibly as a program of the Wisconsin Public Health Council of which the Society is a member.

Conducted in conjunction with such organizations as are grouped in the WPHC, and with invitees from state elected officers, such a round-up should emphasize the public health responsibility involved in the consideration of various problems in the area.

d. Staff Field Service

The committee reported discussions of the staff field service proposed for institution in 1962 to encompass all areas of Society activities. Further details will be presented to the Council in connection with the 1962 budget.

e. Radiation Registration

The committee reported approval to appropriate publicity in the *Wisconsin Medical Journal* on the new law requiring registration prior to January 1 of devices producing radiation. Subsequent developments will be watched by the committee, and efforts made to cooperate in the report which will have to be made to the 1963 Legislature.

* * * * *

Doctor Frank discussed generally other matters before the committee, including a request from a representative of the Wisconsin Osteopathic Association for official contact with the State Medical Society in light of recent action at the national level referring the matter of future relationships with osteopaths to the states.

Doctor Nordby, in view of divergent opinions among osteopaths within the state and nationally, moved that the Planning Committee be authorized to meet with representatives of the Wisconsin Association at the committee level to determine what their opinions and aims are, and then report back to the Council. Motion seconded by Doctor Dessloch and carried.

On motion of Doctors Frank–Nordby, carried, the report of the Planning Committee was adopted as a whole.

6. Administration of Oath to Speaker Callan

Chairman Fox administered the oath of office to Robert E. Callan, M.D., thereby declaring him the incumbent in the office of Speaker of the House of Delegates.

7. Communication to Wisconsin Hospital Association re King-Anderson and Similar Legislation

In light of recent information that a specially called meeting of the House of Delegates of the American Hospital Association would be held in the

near future, at which there was some indication a possible change in position of that Association toward this legislation may be taken, it was suggested that a personally typed letter bearing the signatures of all members of the Council and all Officers of the State Medical Society be directed to the executive office and appropriate officers of the Wisconsin Hospital Association urging their continued opposition to compulsory health insurance, no matter its name.

A proposed draft was reviewed with the Council and approved on motion of Doctors Houghton–Nordby, carried, copies to be sent to members of hospital boards of trustees.

8. Commission on State Department Elections

By separate motion duly made, seconded and carried, the following were elected to vacancies in the Commission on State Departments:

a. Division on Nervous and Mental Diseases

Keith Keane, M. D., Appleton, Chairman
Charles Wunsch, M. D., Green Bay, Vice-chairman

b. Vice-chairman of the Commission

L. M. Simonson, M. D., Sheboygan

9. Museum of Medical Progress

Doctor Nordby, Chairman of the Permanent Commission, advised the Council of the Museum project to solicit funds for an exhibit hall which is badly needed to supplement the limited space in the Fort Crawford Hospital, and which will be named for Doctor Stovall. He proposed that the Councilors not only contribute themselves, but prepare a list among their constituents of physicians who might be written, over their individual signatures, to interest in the project.

Doctor Nordby also suggested that consideration be given to forgiving the balance of the Society loan several years ago to finance the Museum fund drive.

Doctors Egan–Willson said this was a very poor time to solicit, especially in Milwaukee because of hospital construction campaigns, and moved that it be referred to the Finance Committee.

10. Report of Executive Committee

a. Dues for 1962

The committee reported that in the absence of any information from the management survey committee, it had authorized the Secretary to proceed with normal dues billing for 1962 in the amount of $90 state dues and $35 AMA dues.

Doctor Norby: "Mr. Chairman, I note in this recommendation that there will be no billing for a special assessment in 1962. I am not about to debate the merits of the situation, but you recall that the House of Delegates passed having a management survey, the committee was appointed, and while the committee has as yet taken no official action as a committee of the whole, to my knowledge, the chairman has reported to me that they have interviewed management survey companies and that the most prominent one of which he is currently aware has quoted a bid of $32,000 to $40,000 to do the complete management survey as indicated in the resolution. It would be my feeling that we would be remiss in our duty not to begin collecting this assessment, which from my figuring I believe would be safe in the amount of $15 that we authorized up to $25, and that we should have this money in hand before allowing them to go ahead with the survey, because it would be more difficult to collect afterwards than it would before the fact. So I would move that the special assessment in the amount of $15 be added to next year's dues." Motion seconded by Doctor Willson and carried after some discussion as to whether this constituted a report by the survey committee.

Secretary Crownhart subsequently made the following statement: "I would like at this point to discuss from my viewpoint an administrative interpretation that I think is necessary to place upon the action of the Council in directing a special assessment in the amount of $15 on each member of the SMS without regard to his current dues paying status. This will raise in my judgment upwards of $40,000 to $50,000 for the purpose of financing a management survey.

"I must advise the Council that as the board of trustees of the SMS the House of Delegates has not taken from it its statutory and legal responsibility. The appropriation of money to the committee must in my judgment be specific upon what the committee itself and as a committee proposes to do and whom it proposes to employ for the purpose of making the study. So that no councilor or officer may have any misimpression of what I shall do as secretary, and in that capacity as general manager of the Society, I want to summarize my position in the following fashion:

"First, the special assessment will be announced as less than that authorized by the House of Delegates and as applicable to all members of the Medical Society who are in any status of dues paying members.

"Second, that as the money is collected it will be in effect escrowed in a separate account so that in no manner will any of those funds be used for any other purpose than that authorized by the House of Delegates.

"Third, that the staff now proceed to implement the committee, a position in which the staff has not been involved up to this time. It is an official committee of the SMS and under the structure of the SMS staff implementation of all committee structures is a requirement.

"Fourth, that the money will not be released to the committee until the committee brings before the Council and officers the specifics of how it intends to proceed and demonstrates to the Council and officers that it will proceed in accordance with the mandate of the House of Delegates, which includes a management survey of all county medical societies of the SMS and of the two Blue Shield plans in this state.

"Thank you, Mr. Chairman."

Doctors Egan and Willson disagreed with the Secretary's statement on staff implementation of the survey committee, and Doctor Willson asked that the minutes contain a rather complete resume of what has been said on this subject.

(See action of December, 1961, meeting in modification of action in November.)

b. Liaison with Nursing Profession

The Executive Committee reported that representatives of the nurses had met with it in September to explain some of their problems and to express their need for active and continuing liaison with the State Medical Society. The committee recommended that this be accomplished through the Commission on Hospital Relations and Medical Education.

Recommendation accepted on motion of Doctor Deesloch, seconded and carried.

c. Personal Service Corporation Law

The committee reported its general review of text and distribution of the explanatory booklet on this new law, which has been completed.

d. Resolution for Introduction to American Medical Association

The committee recommended approval to introduction of the following resolution forwarded by R. E. Galasinski, M.D., President-elect of the Medical Society of Milwaukee County; recommendation accepted on motion of Doctors Egan–James, carried;

"WHEREAS, The section on General Surgery of the American Medical Association at the June 1961 session of the House of Delegates of the American Medical Association introduced a resolution to sponsor an American Board of Abdominal Surgery to the Advisory Board for Medical Specialties and,

"WHEREAS, The officers of the Section on General Surgery have been instructed to notify the American Board of Abdominal Surgery, in writing, of such sponsorship, and further have been instructed to render all possible assistance to the American Board of Abdominal Surgery in its negotiations for approval by the Advisory Board for Medical Specialties and also for the approval by the Council on Medical Education and Hospitals of the American Medical Association and,

"WHEREAS, It is recognized by the members of the Section on General Surgery of the American Medical Association that the prinicipal business of the Section is conducted in the last minutes of the annual session with little opportunity for proper and complete total planning on the part of the individual Section and sufficient reflection on important matters by members and,

"WHEREAS, Surgeons in many fields of specific interests participate in these section meetings with little verification of identification being exercised and,

"WHEREAS, Many such sessions of the Sections could be 'packed' for purposes of passing resolutions advantageous to specific minority groups,

"THEREFORE, BE IT RESOLVED, That proper identification be required of all members attending the various specialty Section meetings at the American Medical Association annual meetings and that a system for satisfactorily accomplishing proper identification be initiated to insure fair and just representation of bona fide specialists with the various specialty groups."

The balance of the report of the Executive Committee was laid over to the next regular meeting.

11. Special Meeting Date

On motion of Doctors Willson–Nordby, carried, the date of December 16 was accepted for a meeting on the building addition and other special matters.

Doctor Kief asked that the annual report on implementation of House actions be included. This will be scheduled for the next regular meeting.

12. Thanks to the American Medical Association

On motion of Doctors Dessloch–Ekblad, carried, the Council voted a formal expression of thanks to the American Medical Association for arranging this meeting.

13. Adjournment

The Council adjourned at 11:30 a.m.

C. H. CROWNHART
Secretary

Approved:
JAMES C. FOX, M. D.
Chairman

Minutes of Special Council Meeting

Madison, December 16, 1961

1. Call to Order and Roll Call

The Council was called to order by Vice-chairman Bell at 2:00 p.m. on Saturday, December 16, 1961, at Society offices in Madison. All voting members of the Council were present except Doctors Fox, Ekblad and Fons. All members of the Commission on Medical Care Plans were present except Doctors Bernhart, Goldstein, Jeffries and Moore. Officers and others present were President Lokvam, President-elect Hill, Assistant Treasurer Tenney; Doctors Simenstad and Quisling, AMA delegates; Doctors Sullivan and Hildebrand, alternate delegates; Doctor Stovall; Doctor Vingom; Doctor Suckle for item 4; Messrs. Crownhart, Thayer, Ragatz, Toser, Mulady, Murphy, Desmond, Robison, Gill, White, Strang; Mrs. Anderson; Misses Rendall and Pyre.

2. AMPAC—American Medical Political Action Committee

Doctors Dessloch–Egan moved that the Council endorse AMPAC and urge Wisconsin physicians to cooperate with it and its stated aims. Motion carried unanimously.

3. Report of and Action on Bids Relating to State Offices

A report had been sent to the Council of the December 12 meeting of the Board of Trustees of the SMS Realty Corporation, when bids on the building addition had been received on three alternative bases pursuant to Council action in June, namely, three completed floors; two completed floors with the third

roughed in; and two completed floors footed to allow the addition of a third. Low base bids on the completed three-floor addition totaled $332,946, or a construction cost of about $18.30 per square foot as compared with the $17 cost of the original construction, a very favorable bid. Completion of the third floor accounts for $76,200 of the total, or about $12.50 per square foot.

The recommendation of the Trustees was construction of the three floors complete.

The staff and others presented detailed information regarding the addition, which had been reviewed with the Executive and Finance Committees in the morning, consisting of comments on building improvements which have become available since the original construction, by Mr. Strang, architect; exact figures on space utilization as between the State Medical Society proper and WPS, by Mr. Mulady; planned utilization of the third floor of the addition, at least until such time as it may be needed for normal expansion, by Mr. Crownhart; financing by Mr. Murphy.

After a question and answer period, the following action was taken:

On motion of Doctors Mason–Houghton, carried, the Council approved the unanimous recommendation of the Trustees of the SMS Realty Corporation that all three floors of the addition be authorized in their entirety, as shown in the final plans, specifications and bids; and authorized the Trustees, Doctors Dessloch, Tenney and Hill, or their successors, and the Secretary to exercise the same functions as they did in 1954 relating to the office addition, which functions are construction financing, long term financing and leasing, and to make reports to the members of the corporation at appropriate times.

On motion of Doctors Willson–Blanchard carried, the administrative staff was requested to prepare figures for the next meeting of the SMS Realty Corporation showing the impact on the budget of accelerating retirement of the debt to 1986 and 1981.

4. Special Assessment

The Secretary read the portion of combined Resolution G–H, adopted by the House of Delegates in May, 1960, which related to a management survey of the State Medical Society, the component county medical societies and the two Blue Shield plans, as follows:

"*Resolved*, that in the event of inability of the Commissioner of Insurance to act, or upon the completion of his action, and to avoid overtaxing the efficient functioning of the staff by simultaneous surveys, the Speaker of the House of Delegates, with the approval of that body, appoint a six man committee to be composed of two Milwaukee County delegates and four delegates from counties elsewhere in the state, and further, that the House of Delegates charge this committee to select and to supervise a suitable firm of management consultants to conduct a study of structure, function and management of all activities of the State Medical Society and its component counties, including those of the Blue Plans; and be it further

"*Resolved*, that the committee of six make a progress report to the Council six months after its initiation; and be it further

"*Resolved*, that the cost of this activity of the House of Delegates be carried by a special assessment of $25.00 per member of the State Medical Society, any residual funds remaining following completion of the survey to revert to the general funds of the State Medical Society."

He reviewed action taken by the Council at the November, 1961, meeting to levy a $15.00 assessment in 1962, and stated that this posed several problems: "The House of Delegates authorized a $25.00 special assessment. The cost of a management survey might be less than the $25.00, but whatever the management survey may charge does not include costs that may be incurred by the Medical Society in meeting its requests or its need for information and documentation . . . (e.g., reimbursement for time the firm spends interviewing consultants.) I know it was not intended by the House that the budget should be adjusted to those unusual and one-time needs of a management survey, and it was for that very reason that the House authorized a $25.00 assessment if the survey was to be held. Secondly, while the House has empowered activity by a special committee, that does not relieve the Council as the board of trustees of the Society of any of its statutory responsibilities. There may be matters of some character which you must necessarily be involved in and I would think that special meetings of the Council and possibly of the Commission on Medical Care Plans would be necessary . . . Third, I don't think it was intended that the special assessment be levied against the resident member who pays $3.00 dues, or the man retired from active practice, and I would have to assume that the special assessment would be levied against the full dues-paying members . . ."

Doctor Suckle then reported that the committee of six had decided on the firm of Booz, Allen and Hamilton of Chicago, which has proposed to undertake the study for a cost of $32,000 to $40,000.

Doctors Nordby–Willson moved that the November action be changed to assess the full $25.00. Motion carried.

Doctors Frank–Blanchard moved that the Society employ the firm recommended by the survey committee. Motion carried.

Doctors Egan–Schulz moved that the assessment be levied against full dues paying members only. Motion carried.

5. Adjournment

The Council adjourned at 4:10 p.m.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M. D.
Chairman

SPECIALISTS AND GENERAL PRACTITIONERS

Available through Placement Service

The Placement Service of the State Medical Society has registered with it a number of specialists in various fields as well as general practitioners. Contact the Placement Service by writing Box 1109, Madison, Wisconsin.

Education and Leadership for Progress in Wisconsin Medicine

STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING

MAY 8·9·10 1962

MILWAUKEE AUDITORIUM HOTEL SCHROEDER

Milwaukee

Each year brings new discoveries and varying modes of therapy of concern to every alert physician. With this in mind, the Commission on Scientific Medicine has arranged a varied and interesting program for the 1962 Annual Meeting. Participation in this meeting by way of attendance is an important part of a physician's progress in medical knowledge.

1962 ANNUAL MEETING TIMETABLE

MONDAY, MAY 7

All Day—Golf Tournament: Ozaukee Country Club
7:00 p.m.—House of Delegates at Milwaukee Auditorium

TUESDAY, MAY 8

8:00 a.m.—Registration at Auditorium
Exhibits open at Auditorium
9:00 a.m.—Reference Committees, House of Delegates, at Milwaukee Auditorium
9:30 a.m.—General Scientific Program, Milwaukee Auditorium
9.30 a.m.—Program on Internal Medicine, Milwaukee Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Marq. U. and U. of W. medical school's alumni luncheons at Auditorium
2:00 p.m.—Section Meetings on Internal Medicine, Obstetrics and Gynecology, Pathology and Psychiatry at Auditorium
6:00 p.m.—Buffet for Delegates and Officers at Milwaukee Auditorium
7:30 p.m.—House of Delegates at Milwaukee Auditorium

WEDNESDAY, MAY 9

8:00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:00 a.m.—House of Delegates at Milwaukee Auditorium
9.30 a.m.—General Practice Program at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Luncheon for officers and members of SMS Charitable, Educational and Scientific Foundation at Hotel Schroeder
12:15 p.m.—Luncheon for Wisconsin Clinic Managers Association at Milwaukee Athletic Club
2:00 p.m.—Section Meetings on Orthopedic Surgery and Pediatrics at Auditorium
2:00 p.m.—Conference on "Medical Aspects of Sports," Milwaukee Auditorium
6:15 p.m.—President's reception
7:15 p.m.—Annual dinner

THURSDAY, MAY 10

8.00 a.m.—Registration at Auditorium
9:00 a.m.—Exhibits open at Auditorium
9:30 a.m.—Clinic on Dermatology and Allergy at Auditorium
12:15 p.m.—Roundtable luncheons at Hotel Schroeder
12:15 p.m.—Past president's luncheon
1:00 p.m.—Program on Ophthalmology and Otolaryngology at Hotel Schroeder
2:00 p.m.—Section Meetings on Anesthesia, Radiology, and Surgery at Auditorium

OUT-OF-STATE GUEST LECTURERS AND THEIR SCHEDULES

DONALD E. CASSELS, M.D., Chicago
Professor of Pediatrics, University of Chicago Medical School

Wednesday, 2 p.m., South Kilbourn Hall, Aud.
DIAGNOSIS AND TREATMENT OF RHEUMATIC FEVER AND RHEUMATIC HEART DISEASE

VINCENT J. COLLINS, M.D., Chicago
Director, Department of Anesthesia, Cook County Hospital

Thursday, 2 p.m., South Kilbourn Hall, Aud.
NEUROLOGICAL COMPLICATIONS DURING GENERAL ANESTHESIA

JOHN A. EVANS, M.D., New York City
Professor of Radiology, Cornell University Medical College

Thursday, 12:15 p.m., Pere Marq. Rm., Schroeder
NEWER ROENTGEN METHODS IN EXAMINATION OF KIDNEY

Thursday, 2:30 p.m., Walker Hall, Aud.
ROENTGEN STUDIES IN CYSTIC DISEASE OF THE KIDNEY

LEON GOLDMAN, M.D., Cincinnati
Professor of Dermatology, University of Cincinnati Medical School

Thursday, 9:30–12 noon, S. Juneau Hall, Aud.
WET CLINIC ON DERMATOLOGY AND ALLERGY

Thursday, 12:15 p.m., Room 507, Schroeder
SOME CONSIDERATIONS OF METHODS FOR INCREASING THE EFFECTIVENESS OF TOPICAL CORTICOSTEROID PREPARATIONS

ALAN GUTTMACHER, M.D., New York City
Chief of Obstetrics and Gynecology, Mt. Sinai Hospital; Clinical Professor of Obstetrics & Gynecology, Columbia University College of Physicians & Surgeons

Tuesday, 11 a.m., Plankinton Hall, Aud.
THE MEDICAL AND SURGICAL COMPLICATIONS OF PREGNANCY AND THE ROLE OF THE INTERNIST (panel)

Tuesday, 2 p.m., Plankinton Hall, Aud.
CESAREAN SECTION IN TWIN PREGNANCY

Tuesday, 3:45 p.m., Plankinton Hall, Aud.
INDUCTION OF LABOR: PRO AND CON

FRED V. HEIN, Ph.D., Chicago
Secretary, Committee on the Medical Aspects of Sports of the A.M.A.

Wednesday, 2 p.m., Plankinton Hall, Aud.
THE PHYSICAL EXAMINATION FOR HIGH SCHOOL SPORTS PARTICIPANTS

R. W. HOLLENHORST, M.D., Rochester, Minnesota
Associate Professor of Ophthalmology, Mayo Foundation Graduate School (Univ. of Minnesota)

Thursday, 2:45 p.m., East Room, Schroeder
TEMPORAL ARTERITIS

ALFRED W. HUMPHRIES, M.D., Cleveland
Associate Professor of Vascular Surgery, Frank E Bunts Institute (Clev.)

Wednesday, 12.15 p.m., Room 508, Schroeder
ROLE OF EMBOLI IN PRODUCING LIMB ISCHEMIA

Wednesday, 3:45 p.m., Walker Hall, Aud.
REVERSIBILITY OF PREGANGRENE IN THE SEVERELY ISCHEMIC LIMB

JOSEPH M. JANES, M.D., Rochester, Minnesota
Professor of Orthopedic Surgery, Mayo Foundation Postgraduate School, University of Minnesota

Wednesday, 2 p.m., Walker Hall, Aud.
AMPUTATION IN OCCLUSIVE VASCULAR DISEASE

ORMAND C. JULIAN, M.D., Chicago
Professor of Surgery, University of Illinois College of Medicine

Tuesday, 10:45 a.m., Engelmann Hall, Aud.
SURGICAL TREATMENT OF CONGENITAL HEART DISEASE

MAURICE E. LINDEN, M.D., Philadelphia
Assistant Professor of Psychiatry, University of Pennsylvania School of Medicine

Tuesday, 12:15 p.m., Room 507, Schroeder
PROBABLE EFFECT OF COMMUNITY AGENCIES ON THE PERSONALITY DEVELOPMENT OF CITIZENS

Tuesday, 2 p.m., Walker Hall, Aud.
FAMILY ORGANIZATION AND MODERN CHARACTER DEVELOPMENT

ARTHUR M. MASTER, M.D., New York City
Consultant Cardiologist, The Mt. Sinai Hospital, New York, N. Y.

Tuesday, 12:15 p.m., East Room, Schroeder
THE EMERGENCY TREATMENT OF THE COMPLICATIONS OF CORONARY OCCLUSION

Tuesday, 2 p.m., Engelmann Hall, Aud.
THE MASTER '2-STEP' EXERCISE ELECTROCARDIOGRAM

(continued on next page)

OUT-OF-STATE GUEST LECTURERS and their schedules *(continued)*

FRED R. McCRUMB, JR., M.D., Baltimore
Director, Division of Infectious Diseases, University of Maryland School of Medicine

Wednesday, 11:30 a.m., Plankinton Hall, Aud.
CLINICAL TRIALS WITH LIVING ATTENUATED MEASLES vs VIRUS VACCINE

Wednesday, 12:15 p.m., Parlor E, Schroeder
MEASLES AND MEASLES PROPHYLAXIS (including measles encephalitis)

CHESTER B. McVAY, M.D., Ph.D., Yankton, S.D.
Clinical Professor of Surgery, University of South Dakota Medical School; Associate Professor of Anatomy, University of South Dakota Medical School

Thursday, 12:15 p.m., English Rm., Schroeder
CHOLANGITIS

Thursday, 2 p.m., Plankinton Hall, Aud.
ABDOMINAL INCISIONS—A PHILOSOPHY

ROBERT A. MILLER, M.D., Chicago
Assistant Professor of Pediatrics, Northwestern University School of Medicine

Tuesday, 9.30 a.m., Engelmann Hall, Aud.
ACUTE DIFFUSE VIRAL MYOCARDITIS

ROBERT MURPHY, M.D., Columbus, Ohio
Assistant Clinical Professor of Medicine, Ohio State University; Medical Consultant, Ohio Rehabilitation Center; Team Physician, Ohio State University, Department of Athletics

Wednesday, 2 p.m., Plankinton Hall, Aud.
WITHHOLDING PARTICIPANTS FROM SPORTS AND RETURN TO COMPETITION (special conference)

EDMUND R. NOVAK, M.D., Baltimore
Assistant Professor of Obstetrics & Gynecology, Johns Hopkins University School of Medicine

Tuesday, 9:30 a.m., Plankinton Hall, Aud.
ENDOCRINE ASPECTS OF ENDOMETRIAL ADENOCARCINOMA (panel)

Tuesday, 2:45 p.m., Plankinton Hall, Aud.
THE STEIN-LEVENTHAL SYNDROME

Wednesday, 12:15 p.m., Parlor D, Schroeder
DYSMENORRHEA

WILLIAM J. OLIVER, M.D., Ann Arbor
Assistant Professor of Pediatrics, University of Michigan Medical School

Wednesday, 12:15 p.m., English Rm., Schroeder
PHYSIOLOGICAL EVENTS PRECEDING STEROID-INDUCED DIURESIS IN NEPHROSIS

Wednesday, 2:30 p.m., S. Kilbourn Hall, Aud.
PROBLEMS IN THE DIAGNOSIS AND TREATMENT OF ACUTE NEPHRITIS IN CHILDREN

DAVID G. PUGH, M.D., Rochester, Minnesota
Professor of Radiology, Mayo Foundation Graduate School (University of Minnesota)

Thursday, 2 p.m., Walker Hall, Aud.
BENIGN BONE TUMORS OF THE EXTREMITIES

Thursday, 7 p.m., University Club
SKELETAL CHANGES CAUSED BY RENAL DISEASE (dinner meeting, Wisconsin Radiological Society)

RALPH A. REIS, M.D., Chicago
Professor of Obstetrics & Gynecology, Northwestern University School of Medicine

Tuesday, 12:15 p.m., English Rm., Schroeder
ENDOMETRIOSIS

ADOLPH ROSTENBERG, JR., M.D., Chicago
Professor of Dermatology and Chairman of the Department of Dermatology, University of Illinois College of Medicine

Thursday, 9:30–12 noon, S. Juneau Hall, Aud.
WET CLINIC ON DERMATOLOGY AND ALLERGY

Thursday, 12.15 p.m., Room 508, Schroeder
PATCH TESTING: INDICATIONS AND TECHNIQUES

ROBERT E. SCULLY, M.D., Boston
Assistant Clinical Professor of Pathology, Harvard University School of Medicine

Tuesday, 9:30 a.m., Plankinton Hall, Aud.
ENDOCRINE ASPECTS OF ENDOMETRIAL ADENOCARCINOMA (panel)

Tuesday, 3:45 p.m., N. Kilbourn Hall, Aud.
GERM CELL TUMORS OF THE OVARY

JOHN W. SEVERINGHAUS, M.D., San Francisco
Associate Professor of Anesthesiology, University of California Medical School

Thursday, 12:15 p.m., Parlor A, Schroeder
THE ANESTHESIOLOGIST AS RESPIRATORY CONSULTANT

Thursday, 2 p.m., S. Kilbourn Hall, Aud.
THE PULMONARY CIRCULATION

GEORGE L. WIED, M.D., Chicago
Associate Professor of Obstetrics & Gynecology, University of Chicago, and Director of Cytology, University of Chicago Hospitals

Tuesday, 12:15 p.m., Pere Marq. Rm., Schroeder
HORMONAL CYTOLOGY

Tuesday, 2:30 p.m., N. Kilbourn Hall, Aud.
DIFFERENTIATION OF CERVICAL LESIONS (Dysplasia, Carcinoma in situ, and Invasive Carcinoma) BY MEANS OF CYTOMETRY AND ROUTINE CYTOLOGICAL EXAMINATIONS

WALTER P. WORK, M.D., Ann Arbor, Michigan
Professor of Otolaryngology, University of Michigan Medical School

Thursday, 2 p.m., East Room, Schroeder
CANCER OF THE LARYNX

HIGHLIGHTS

COMPLETE PROGRAM IN MARCH ISSUE

TUESDAY MORNING
9:30 to 12:00

Your Female Patient and Special Problems She Presents

Arranged in cooperation with the Wisconsin Society of Obstetrics and Gynecology

PLANKINTON HALL
Milwaukee Auditorium

GUEST LECTURERS: Robert E. Scully, M.D., Boston; Edmund R. Novak, M.D., Baltimore; Alan Guttmacher, M.D., New York City; Ralph Reis, M.D., Chicago; and Charles L. Junkerman, M.D., Milwaukee.

TUESDAY MORNING
9:30 to 11:45

Special Program on Cardiology

Arranged in cooperation with the Wisconsin Society of Internal Medicine

ENGELMANN HALL
Milwaukee Auditorium

GUEST LECTURERS. Robert A. Miller, M.D., Chicago; Ormand C. Julian, M.D., Chicago, and John H. Huston, M.D., Milwaukee.

Medical Aspects of Sports

WEDNESDAY 2:00 P.M.

PLANKINTON HALL, MILWAUKEE AUDITORIUM

All physicians directly associated with high school athletic programs are urged to attend this conference. This will be an exchange of views designed to assist physicians and high school administrators in carrying out athletic programs.

THURSDAY MORNING
9:30–12:00

Wet Clinic on Dermatology, Allergy

SOUTH JUNEAU HALL, AUDITORIUM

Cases presented through Donald M. Ruch, M.D., Milwaukee, for the Wisconsin Society of Dermatology, and Harry Weil, M.D., Milwaukee, for the Wisconsin Society of Allergists.

DISCUSSANTS: Leon Goldman, M.D., Cincinnati, and Adolph Rostenberg, Jr., M.D., Chicago.

WEDNESDAY MORNING
9:30 to 12:00

External Cardiac Massage

PLANKINTON HALL, AUDITORIUM

Program arranged in cooperation with the Wisconsin Academy of General Practice. Movies, demonstrations and comments by Karl Siebecker, M.D., Madison, and John H. Huston, M.D. Milwaukee.

Because local groups of firemen, lifeguards, law enforcement officers, etc. will request M.D. instruction in this technique, it is important that every hospital staff in the state has at least one M.D. in attendance at the morning program and at one of the instructional periods Wednesday afternoon and Thursday morning.

WEDNESDAY AFTERNOON—2 to 5 p.m.
THURSDAY MORNING—9 to 12 a.m.

Individual demonstrations and explanation with manikin in Committee Room D, across corridor of Plankinton Hall, 2nd floor.

Woman's Auxiliary

1962 ANNUAL CONVENTION

MRS. J. HOWARD JOHNSON
Milwaukee
State President

MRS. E. M. DESSLOCH
Prairie du Chien
President-elect

PROGRAM HIGHLIGHTS

MONDAY, MAY 7

3:00 p.m.—REGISTRATION
Main Lobby, Hotel Schroeder

5:30 p.m.—GET-ACQUAINTED HOUR
Colonial Room, Wisconsin Club

6:30 p.m.—BOARD OF DIRECTORS DINNER AND MEETING
MacArthur Room, Wisconsin Club
Those who attend: State Officers, State Chairmen, Councilors, County Presidents and Presidents-elect, Past State Presidents, Past National President and Honored Guests

TUESDAY, MAY 8

8:00 a.m.—REGISTRATION
Main Lobby, Hotel Schroeder

9:00 a.m.—CONTINENTAL BREAKFAST
Loraine Room, Hotel Schroeder

9:45 a.m.—FIRST BUSINESS SESSION

12:30 p.m.—LUNCHEON AND FASHION SHOW
Milano Room, Milwaukee Athletic Club
Honoring Mrs. Karl F. Ritter, Lima, Ohio; Finance Chairman, Woman's Auxiliary to the American Medical Association
Fashions by The Boston Store
(Guest privileges)

WEDNESDAY, MAY 9

8:00 a.m.—REGISTRATION
Main Lobby, Hotel Schroeder

9:00 a.m.—CONTINENTAL BREAKFAST
Loraine Room, Hotel Schroeder

9:45 a.m.—SECOND BUSINESS SESSION
Memorial Service
Election of Officers
Installation of Officers—Mrs. Karl F. Ritter

12.00 noon—LUNCHEON AND MATINEE
Swan Supper Club and Theater
Play will be "Guys and Dolls"
(Guest privileges)

MRS. KARL STAHMER
Wausau
Convention Chairman

MRS. WILLIAM NORTON
Wausau
Convention Co-chairman

MRS. KARL RITTER
Lima, Ohio
Finance Chairman
Woman's Auxiliary to the A.M.A.

WEDNESDAY, MAY 9

6:15 p.m.—RECEPTION OF THE PRESIDENT OF THE STATE MEDICAL SOCIETY OF WISCONSIN
East Room, Hotel Schroeder

7:15 p.m.—ANNUAL DINNER OF THE STATE MEDICAL SOCIETY
Crystal Ballroom, Hotel Schroeder

the Wisconsin Medical Journal

MAY 1962

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NUMBER 5

VICTOR S. FALK, JR., M. D.

New Medical Editor

Dr. Victor S. Falk, Jr., Edgerton, was appointed medical editor of the *Wisconsin Medical Journal* at a meeting of the Council in February. He received his medical education at the University of Wisconsin, served his internship at Ancker Hospital, St. Paul, Minnesota and took his surgical training at Carle Hospital Clinic, Urbana, Illinois and Augustana Hospital, Chicago, Illinois. A fellow of the American College of Surgeons, he is chief of staff at Edgerton Memorial Community Hospital and a staff member of Mercy Hospital, Janesville.

The role of the state medical journal in scientific education has assumed increased importance. Standards of publication are becoming higher. Competition for physicians' time and for financial support never was greater. It will become more so.

In recent years every member of the Editorial Board of our Journal has participated actively in gathering and processing scientific material for it.

The members of our Society are fortunate, then, that we can turn to a man of the caliber of V. S. Falk to guide the destinies of the Journal and to coordinate the work of the Editorial Board.

He is an omnivorous reader with a photographic memory. He brings to the medical editorship experience in the publishing field.

He has served your Society as a member of the Editorial Board since 1953. As assistant medical editor during the past year, he has taken over the responsibilities of his new position and is well able to usher our Journal into a new era in medical journalism.

—R.S.B.

Traumatic Arteriovenous Fistula

Report of an Asymptomatic Case of 40 Years Duration

By W. C. GORMAN, M. D., and DERWARD LEPLEY, JR., M. D.
Milwaukee, Wisconsin

THIS IS a report of a patient who had a large traumatic arteriovenous fistula without serious disturbing symptoms for 40 years. The sudden occurrence of tremendous overwork of the heart produced physiologic derangements that created an unusual surgical problem.

William Hunter described the first traumatic arteriovenous fistula in 1757. Only rare reports of this condition appeared in the literature until World War II when the creation of vascular centers permitted the accumulation of a large number of these cases and a careful study of abnormal physiology involved. In spite of the large number now reported we have not found a case in the literature similar to the one we herewith report.

CASE REPORT

A 67-year-old white man was admitted to a Veterans Administration hospital on July 8, 1960, with a chief complaint of ankle swelling and shortness of breath of two weeks duration. He also complained of an oppressive chest pain which was relieved by rest.

This patient suffered a gunshot wound to the left side of the neck in 1921 at the age of 27. He noted immediate swelling and pain within the area of the wound of entrance; and although the pain subsided within several days, the swelling persisted. Soon after the gunshot wound, he noted buzzing in the left ear which persisted to the present time. The injury was also associated with aphasia of two years duration and a partial right hemiparesis with some permanent residual. No other cardiovascular symptoms occurred until the present illness—40 years after the initial injury.

From the Division of Surgery, Section of Thoracic Surgery, Marquette University School of Medicine and Wood Veterans Administration Hospital, Milwaukee, Wisconsin.

He was a well-developed, well-nourished white man in no acute distress. Blood pressure was 150 systolic, 60 diastolic; pulse was 135 and irregular. The larynx and trachea were in the midline; the thyroid was of normal size and shape. In the left side of the neck there was an 8 x 8 cm. pulsatile mass over which there was a continuous thrill and bruit. There were many large dilated superficial veins overlying the mass. He had fine, moist rales at the lung bases. The point of maximum impulse of the heart was in the seventh intercostal space in the mid axillary line. The apical pulse was irregular. There was a Grade 3 systolic murmur present over the precordium which radiated to the left side of the chest. The liver was palpable 4 cm. below the right costal margin and there was 4+ pitting edema of the lower legs and feet. There was muscular atrophy and weakness of the right arm and leg.

His hemoglobin level was 13.5 gm. per 100 ml., hematocrit reading 46%, urinalysis normal. Serum electrolytes were normal. A chest x-ray film showed marked cardiac enlargement (Fig. 1a) and the electrocardiogram showed auricular fibrillation.

Treatment with digitalis and diuretics resulted in the slowing of the heart rate, clearing of the lungs, disappearance of the peripheral edema and a weight loss of 15 pounds. Venous pressure three days after admission (July 11, 1960) was 210 mm. of water, and 22 days after (July 30, 1960) was 127 mm. of water. Catheterization on the right side of the heart was performed 11 days after admission (July 19, 1960). (Table 1). The patient was aware of the presence of the arteriovenous fistula for many years, but he refused surgery on several previous occasions because of the absence of symptoms other than chronic "buzzing" in the ear. With the onset of a cardiac failure, however, he agreed to surgical correction.

Fig. 1a—Preaperative x-roy film of chest. Note cardiomegaly present. The patient at this time was in obvious failure. The enlargement of the left side af the neck caused by the fistulo con also be seen.

Fig. 1b—Postaperative posteroonterior x-roy film of chest. Heart size is greatly diminished and the mass in the neck is gone.

TABLE 1

Measurement	Preoperative Resting Values	Postoperative Values	
		Rest	Exercise*
Oxygen consumption (ml. min.)	261.0	136.0	433.0
Cardiac output (L./min.)	14.3	4.0	8.7
Estimated shunt flow (L. min.)	10.8		
Estimated nonshunt flow (L. min.)	3.5		
Cardiac index (L./min./sq. M)	8.0	2.2	5.0
Ventricular rate (/min.)	93.0	94.0	108.0
Stroke volume (ml.)	153.0	42.0	80.0
Pressures in mm. Hg.			
Brachial artery (systemic)	135/48 (85)**	92/62 (77)	107/75 (91)
Pulmonary artery	68/23 (44)	22/9 (13)	27/11 (18)
Pulmonary artery wedge	20	4	3
Right ventricle	72/8	22/2	28/3
Right atrium	14	2	1
Resistance in dynes, sec. cm.$^{-5}$			
Total peripheral resistance	398	1499	811
Total pulmonary resistance	246	260	166
Ventricular work in Kg. M./min.			
Left ventricular work	9.18	2.27	6.16
Right ventricular work	3.44	.35	1.22

*Exercise consisted of alternate leg raising at 30/minute. The patient was not exercised preoperatively.
**Figures in brackets, ( ), are mean pressures.

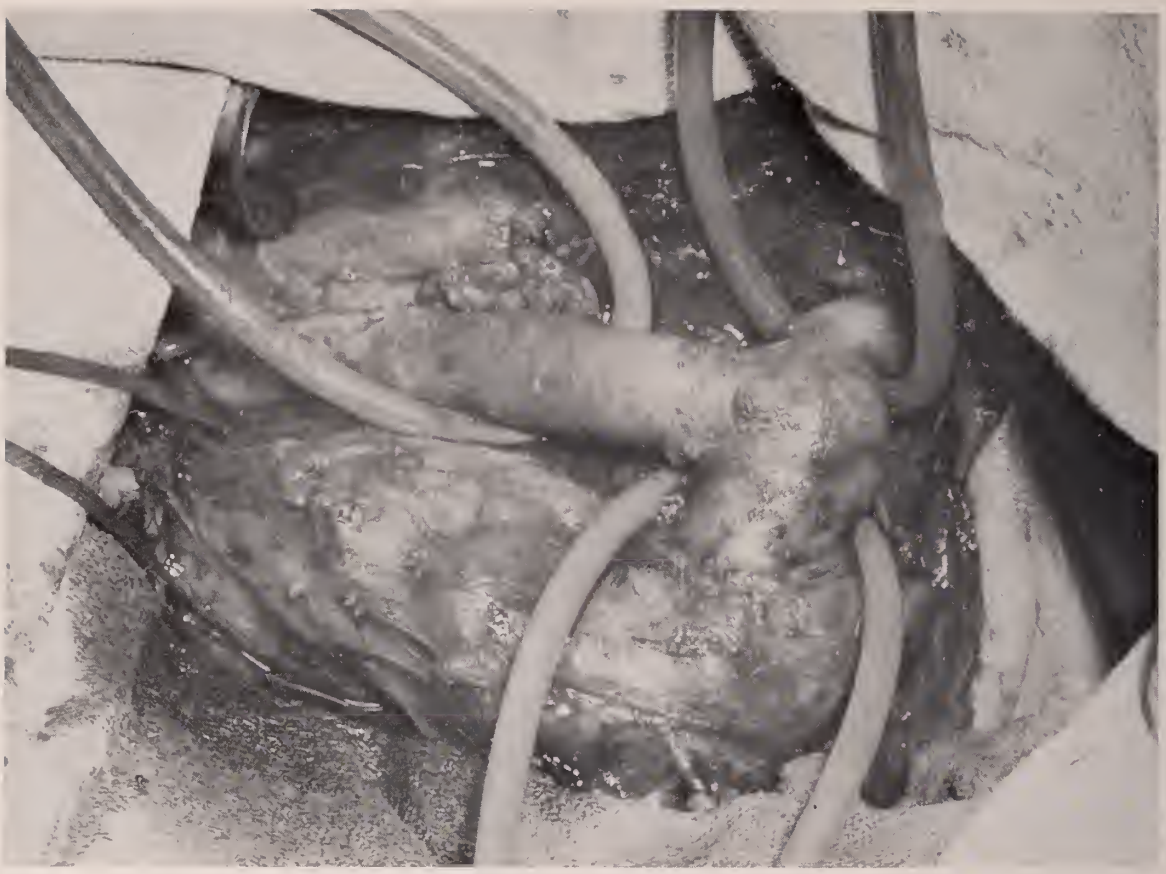

Fig. 2a—A picture of the fistula after dissection at the operating table. The two rubber loops superiorly encompass the cammon carotid artery on each side of the fistula. The bottom loap is around the fistula. Inferior to this, the greotly dilated jugular is seen.

On Aug. 1, 1960, the patient underwent surgery under general anesthesia and hypothermia. After suitable exposure was obtained, the common carotid artery was observed to be approximately 2.5 cm. in diameter. The fistula was 3 cm. in diameter (Fig. 2a). The fistula was excised, the carotid artery repaired by primary approximation, and the stump of the fistula arising from the vein oversewn (Fig. 2b). The carotid artery was occluded 12 minutes. At the time of occlusion of the fistula there was no decrease in the heart rate or change in the peripheral blood pressure. The postoperative course was uncomplicated and postoperative heart catheterization was performed on Sept. 8, 1960 (Table 1). Following surgery, the auricular fibrillation was converted to a normal sinus rhythm by quinidine. However, auricular fibrillation returned one week following cessation of quinidine therapy and has persisted. Heart size diminished rapidly postoperatively (Fig. 1b).

COMMENT

The long duration of a large arteriovenous shunt which failed to cause subjective symptoms is extremely unusual. Previous reports have shown that patients are often treated for heart failure for a considerable length of time before an arteriovenous fistula is recognized as the cause of the failure.[1, 2]

In 1953, Epstein, et al.,[3] reported seven cases of arteriovenous fistula in which cardiac catheterization was performed and showed various effects of the occlusion of the fistula on the cardiovascular system including a decrease in the pulse pressure, decrease in pulse rate, decrease in cardiac output and decrease in arterial pressure.

Schreiner, in 1955, discussed the physiology of arteriovenous fistulas and pointed out the various reasons for the physiologic effects.[4, 5] As can be seen from the catheterization data in Table 1, this patient manifested several of the typical physiologic changes that accompany a fistula. The

Fig. 2b—After excision of the fistula. The oversewn jugular stump of the fistula is seen at the bottom center of the picture.

cardiac output was more than three times that of the postoperative resting state. The estimated shunt flow was three times the nonshunt flow. The stroke volume was increased and the pressures on the right side of the heart were considerably elevated. The patient did not have a decrease in pulse rate with occlusion of the fistula (Branham's sign); however, he did show a typical decrease in the pulse pressure. We are at a loss to explain this patient's prolonged asymptomatic course, resulting in failure after 40 years.

SUMMARY

A patient with a large arteriovenous fistula of 40 years duration was asymptomatic until six weeks prior to surgical treatment. Pre- and postoperative catheterization studies of the right side of the heart showed results compatible with heart failure on the right side and then a return to normal following division of the arteriovenous fistula.

(D. L.) 8700 W. Wisconsin Avenue.

REFERENCES

1. Muller, W. H., Jr. and Goodwin, W. E.: Renal arteriovenous fistula following nephrectomy, Ann. of Surg., 144:240–244 (Aug) 1956.
2. Smith, V. M., et al.: High-output circulatory failure due to arteriovenous fistula (complication of intervertebral-disk surgery), A.M.A. Arch. of Int. Med. 100:833–841 (Nov) 1957.
3. Epstein, F. H., et al.: Cardiac output and intracardiac pressures in patients with arteriovenous fistulas, J. Clin. Invest. 32:543–547 (June) 1953.
4. Schreiner, G. E.: Physiology of arteriovenous fistulas, Davidson lecture for 1953, M. Ann. District of Columbia 24:1–11, 54 (Jan) 1955.
5. Schreiner, G. E., et al.: Cardiac output, central volume and dye injection curves in traumatic arteriovenous fistulas in man, Circulation 7:718–723 (May) 1953.

RECOMMENDATIONS FOR THE PARTICIPATION OF PHYSICIANS IN COMMUNITY POLIO-VIRUS VACCINE PROGRAMS

By the American Medical Association House of Delegates,
New York City, June 25–30, 1961

1. Physicians should encourage, support, and extend the use of Salk vaccine on the widest possible scale at least until the oral poliovirus vaccines currently under development and clinical trial become available.
   a. All individuals below the age of 50 should be protected with Salk vaccine.
   b. Optimal protection is provided by a complete series of 3 basic injections plus at least one booster.
   c. Special emphasis should be placed upon preschool children, young adults, and all not fully immunized previously.

2. When poliovaccines become available, all physicians should take the leadership in initiating, supporting, and participating in intensive community-wide, mass vaccination programs.
   a. Community-wide mass vaccination programs present a unique opportunity to eliminate paralytic poliomyelitis from the community.
   b. Such programs, to be successful, will require the active cooperation of various community organizations and agencies in addition to organized medicine; public health agencies, hospitals, pharmacists, nurses, mass communication organizations, service clubs, etc.
   c. The detailed planning for any community program must be adapted to local interests, services, and resources.
   d. The selection of well located vaccination stations capable of, and staffed for, handling large numbers of persons quickly and comfortably will be essential to the success of mass programs.
   e. Provision should be made for including in the mass program institutionalized individuals, i. e., those in hospitals, jails, etc.
   f. Recommended immunization calls for the administration of Type 1, Type 3, and Type 2 oral poliovaccines in that order at six week intervals, each type being given to all candidates within a relatively brief (2 week) period, followed by the administration of a single dose of the three vaccines combined, in accordance with the manufacturer's directions.
   g. Except in the face of an impending epidemic in the community, the mass vaccination program should not be carried out during the "polio season."
   h. However, if an epidemic threatens, prompt mass administration of the type involved is of the utmost importance to the public health. Decision in such circumstances should be made by the public health authorities and should be supported actively by all physicians.

3. In addition to the community-wide, mass vaccination program, physicians should promptly establish a maintenance program for the community, including:
   a. For newborns, administration of Type 1 vaccine should be carried out within the first 3 days after birth, in addition to the program outlined in 3 (b) starting at 6 weeks of age.
   b. Administration of Type 1, Type 3 and Type 2 oral poliovaccines at six week intervals to all persons six weeks of age or older who have not previously received the oral vaccines. A single dose of the three vaccines combined should be administered 10 to 12 months later.
   c. Although this phase of the program may well be carried out largely in the physician's private practices, provision must be made for the administration of the oral vaccine to all newborns in hospitals, and for those who, for financial or other reasons, would not receive the vaccine except through a community clinic program.

4. In all programs, provisions should be made to furnish a record of the administration of live attenuated poliovirus vaccine to the patient, to the private physician, and to the health department. Development by the American Medical Association of a standard personal record card for polio and other immunizations should be considered.

5. In the light of present knowledge, physicians may be assured that the relative risks involved

(Continued on page 281)

An Unusual Case of Traumatic Perforation of the Hypopharynx

By JAMES W. MANIER, M. D.
Marshfield, Wisconsin

TRAUMATIC perforation of the esophagus is an increasingly common injury with a serious prognosis.[1, 2] It is usually secondary to instrumentation such as dilatation, esophagoscopy, or gastroscopy. Seybold and co-workers[3] in 1949 were able to find only 27 cases involving the cervical esophagus and hypopharynx. Seventeen of these were caused by endoscopy and only 7 by foreign bodies. A recent review by Shaw[4] of 23 individuals with esophageal perforation seen from 1946 to 1948 revealed only 4 due to foreign body and of these 3 were in the cervical esophagus and hypopharynx. In most instances the perforation was recognized shortly following the acute episode.

Foreign bodies impact in the areas of physiologic narrowing, the first of which is the cricopharyngeus. Sharp foreign bodies such as pins and pieces of bone usually perforate immediately while others such as coins erode slowly. Bisgard and Kerr[5] described three types of perforations: (1) minute perforations from pins or fish bones, (2) slow erosions as from coins, and (3) gross immediate tearing or penetrating wounds as from endoscopic instruments or large bones.

CASE REPORT

This 70-year-old white woman was admitted to the hospital on June 25, 1960. Ten days prior to admission she swallowed a chicken bone. She felt at the time that it stuck in her throat momentarily, but subsequently it had seemed to pass through. She had no further symptoms until the day of admission when eating a supper, consisting of mashed potatoes and wieners, she suddenly noticed that a bolus of food seemed to stick in her throat. Despite vigorous attempts to induce vomiting she had a persistent feeling of a lump in her throat. Her voice was noted to be quite husky by her daughter. A feeling of tightness in her neck and shoulders developed on the way to the hospital.

She was apprehensive, her voice was husky, but she did not otherwise appear ill. Subcutaneous emphysema was palpated over the upper chest and neck. Her temperature was normal. In the hypopharynx was a small blood clot beneath which was a 2mm. linear perforation of the posterior wall. The wound was probed and no foreign body was found. A biopsy of the area revealed only inflammatory changes.

Her blood cell count was normal except for a white blood cell count of 22,850 and a differential of 11 bands, 81 neutrophils, 7 lymphocytes and 1 monocyte. On an x-ray film of the chest subcutaneous emphysema in the neck was seen. An esophogram was made with diatrizoate methylglucamine (Renografin). It showed an irregularity at the level of the second cervical body extending posteriorly from the hypopharynx.

The patient was treated with 600,000 units of penicillin intramuscularly each 12 hours, streptomycin 0.5 gm. each 12 hours, and intravenous fluids for the first 5 days of hospitalization. Thereafter, her diet was gradually increased to normal. She had a low-grade fever for the first 5 days but was afebrile thereafter. By the time of discharge her white blood cell count and differential returned to normal. Twelve days later no evidence of emphysema was seen on a chest x-ray film. Following discharge from the hospital the patient has remained asymptomatic until the present.

DISCUSSION

Symptoms of perforation of the cervical esophagus and hypopharynx are similar. They consist of difficulty in swallowing, pain in the throat and in the chest and back if infection supervenes and spreads to the mediastinum. In this event the temperature will be elevated. Subcutaneous emphysema

From the Marshfield Clinic Foundation.

Fig. 1—Lateral view of the neck showing subcutaneous emphysema.

of the neck is perhaps the most helpful diagnostic sign. If the perforation is small this may not be present. A change in the voice is often noted. It has a peculiar nasal twang which is probably due to air in the tissue.

Of the physical findings the presence of subcutaneous emphysema is the most helpful. Often the actual site of the perforation can be seen with the use of a tongue blade and flashlight. Endoscopic examination may be necessary.

Roentgenographic study is perhaps the most important diagnostic aid. Plain films of the neck and the thorax are usually sufficient. Often however, examination of the esophagus with radiopaque liquids may help in localizing the perforation. It is strongly recommended that barium not be utilized in roentgenologic studies because of the undesirability of barium getting into the mediastinal tissues. Leukocytosis may accompany the perforation.

The differential diagnosis should include spontaneous pneumothorax, thyroiditis, acute pharyngitis, acute laryngitis, coronary occlusion, esophagitis, and pneumonitis. These can usually be differentiated by proper diagnostic studies.

Treatment of these perforations most commonly is surgical. Many reports now point to the excellent results obtained from surgery, and the high mortality when surgical therapy is not utilized or delayed. Surgical drainage is the commonly utilized procedure,

Fig. 2—Esophogram, lateral view, showing dye extruding into the posterior perforation near the hypopharynx.

coupled with massive doses of antibiotics. Hospitalization in most instances is a necessity so that closer observation can be carried out.

Mathewson[6] describes 11 cases of cervical perforation treated conservatively without fatality and 2 deaths among 6 others subjected to cervical mediastinotomy. Kernan[7] has experienced similar results. Korkis[8, 9] is in favor of a trial with conservative therapy prior to surgical intervention, but emphasizes that careful observation is a necessity. He recommends early operation for instrumental injuries, and also for foreign body perforations if there is any doubt about the outcome. Touroff[10] favors a trial of conservative treatment providing there is no radiographic evidence of abscess or foreign body in the periesophageal tissues. Shaw[4] feels that while some patients may recover with the liberal use of antimicrobial agents alone, prompt

incision and drainage of the periesophageal space will result in the saving of more lives and prevent protracted periods of chronic illness due to fistula, stricture and persistent abscess.

In our patient the perforation was so minute we believed a trial of conservative therapy was safe. The possibility of the need for surgical treatment was constantly kept in mind throughout the patient's stay in the hospital. Fortunately the patient did not require instrumentation other than exploration of the wound for foreign body.

It is interesting to speculate about why the symptoms in this individual did not appear until 10 days after the perforation of the hypopharynx. To my knowledge Russell's case of spontaneous perforation in this area is the only one reported.[11] Necrosis of the esophageal wall following pressure from an impacted foreign body or from an instrument pressing against the cervical spine has been reported. In our patient the bone was apparently quite small and there was no evidence of pressure necrosis. It is suspected that a small mucosal lesion was produced by trauma from the chicken bone and that subsequently a low-grade infection developed at the site of the erosion. With the increased pressure developed during the act of swallowing of the bolus of food, final perforation through all the layers of the esophagus occurred and her symptoms appeared.

SUMMARY

A 70-year-old woman developed symptoms from a perforation of the hypopharynx 10 days after swallowing a chicken bone which apparently injured the mucosa, weakened the wall and led to the perforation. Subcutaneous emphysema of the neck was felt and was demonstrated by x-ray. She responded to conservative treatment. Most patients with perforation of the esophagus require surgery, but where the lesion is small, as in our patient, recovery will take place without operation.

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POLIOVIRUS VACCINE PROGRAMS *continued from page 278*

to individuals and to the entire community will be minimal when a mass, community-wide program using the oral poliovaccines is conducted as recommended.

a. The attack rates of paralytic poliomyelitis in any community will be greatest, all other factors being equal, when neither the formol-killed vaccine nor the live, attenuated vaccine has been widely used, and will be lowest (approaching elimination) when recommendations 2 and 3 above have been properly and thoroughly carried out.

b. The only known contraindication to the administration of oral poliovaccines, when available, is an acute respiratory or febrile illness. In such instances, provision should be made to complete the individual's immunization program by administering the appropriate vaccine type at a later date, *whether or not* the dosage was skipped during the mass program.

Clinical Note

Observations on the Effectiveness of Cranberry Juice in Urinary Infections

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FOLKLORE MEDICINE has often mentioned cranberry juice as being used by the women for the relief of the frequent and ancient complaint of dysuria. The juice has been widely used in the Cape Cod area of Massachusetts in the treatment of urinary tract infections.

In 1923, Blatherwick and Lang studied the effects of feeding cranberries to human beings and found that they could produce an increase in the hippuric acid in the urine. Ten years later Fellers determined that the quinic acid in cranberries was the precursor of the hippuric acid which is a strong antibacterial agent.

An article appearing in *The Journal of Laboratory and Clinical Medicine*, December, 1959, regarding the use of cranberry juice in chronic urinary tract infections, stimulated my interest in the problem. The article reiterates that cranberry juice contains quinic acid which is converted to hippuric acid which in turn has a strong antibacterial action in the urine.

Our observations have been made on patients seen in a general practice of medicine. Our impressions are based on objective and subjective patient response.

One of the most common complaints encountered in general practice is recurrent dysuria, frequency, and urgency of urination in the female patient. A large percentage of these women have a negative urine, both grossly and microscopically. They do not respond satisfactorily to sulfas, antibiotics, bladder sedatives, urethral dilations or bladder irrigations. If there is a response, it is often of short duration, the symptoms will recur and can be very persistent in spite of the usual treatments.

This particular group has been most gratifyingly relieved of all urinary symptoms as long as they continue to take two 6-oz. glassfuls of cranberry juice daily. Into this group will fall the patients with chronic urethritis, with or without caruncle formation and those with so-called chronic trigonitis. Also, the male patient who has recently had a transurethral resection and has urinary frequency will often have relief of symptoms if cranberry juice is taken daily.

Chronic pyelonephritis remains a difficult therapeutic problem. The condition carries the threat of kidney deterioration and requires continuous lifetime treatment. There is no effective universally accepted prescription for this condition. The drugs recommended are expensive and often toxic to the patient.

Our interest in this problem was stimulated by the response of a 66-year-old lady with proved chronic pyelonephritis. The disease was known to have existed for five years prior to 1959, and she had been given continuous drug therapy under careful supervision for the entire five-year period. Many drugs were used for extended periods without demonstrable effect on the patient or on her persistent 4 + albuminuria or 4 + pyuria.

Cranberry juice was begun in January, 1959; the patient took 6 oz. with the morning and evening meals. This was the only medication given to this patient for the next two and one-half years. After eight weeks of the juice therapy, the urine gradually began to clear. At the end of nine months, there were only occasional pus cells in voided centrifuged specimens, and no albumin. The urine is still negative, and the patient refuses to stop the cranberry juice because she feels so much better and knows no other medication has helped her before.

Patients with recurrent kidney stones need continuous therapy, and again we are faced with the problem of what to recommend for prolonged therapy. From our short experience with cranberry juice therapy it is felt

that the hippuric acid produced in the urine from cranberry juice can be an effective deterrent to the formation of recurrent stones and possibly arrest the progression of existing staghorn-type stones.

This problem is being followed and no definite conclusions can be drawn yet, but we feel that after two years observation it holds enough promise to be mentioned at this time.

The Almost Forgotten Murphy Button

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ALTHOUGH mechanical devices had been utilized for intestinal anastomosis since the twelfth century, it was not until John B. Murphy popularized his so-called "Murphy Button"[1] in 1892 that gastrointestinal anastomosis was performed in any degree of volume by the utilization of mechanical devices. At Salerno in the twelfth century Ruggiero Frugardi[2] performed intestinal anastomosis over an elder wood tube. Later he utilized a piece of trachea which had the special advantage of being absorbed. The late Dr. A. A. Berg employed the Murphy Button frequently in the performance of an anastomosis between the stomach and the intestine,

Fig. 1—X-ray film of the stomach showing large gastric ulcer an the lesser curvature.

Fig. 2—The Murphy Button in place after gastric resection.

Fig. 3—Status after gastric resection shawing extent of resectian.

when he desired to perform a rapid procedure or to do an extensive gastrectomy. I have utilized this procedure for many years, but in speaking to other surgeons and medical students I have found that the procedure has amost been abandoned. It has certain special advantages, and I believe it should be a part of every surgeon's armamentarium. It can be utilized when a rapid procedure is desired or when a very high gastric resection is performed. When employed, however, the anastomosis should be reenforced with interrupted serosal stitches. I have not found it either necessary or advisable in the performance of anastomoses in other parts of the gastrointestinal tract.

CASE REPORT

The case herewith presented is that of a colored woman who began to complain of gastrointestinal symptoms in 1958, and who on x-ray examination of the stomach was found to have a large ulcer on the lesser curvature (Fig. 1). The patient submitted to gastric resection on Nov. 5, 1958, using a Murphy Button (Fig. 2). The Murphy Button was passed on Nov. 26, 1958. Fig. 3 indicates the extent of the resection and the efficiency of the anastomosis.

SUMMARY

Although the Murphy Button need not necessarily be employed in the routine type of gastric resection for duodenal ulcer, it can be very advantageously and successfully employed for gastric resection when a very high or rapid resection is desired.

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VOLUME OF A SWALLOW

Doctors Daniel V. Jones and Charles E. Work, both of Cincinnati, conducted a study on the volume of a swallow and published the result in the *American Journal of Diseases of Children*, September, 1961. Their findings were presented because the information would be helpful to those physicians who must treat cases of accidental ingestion of poisons.

The normal swallow of water for an average adult averaged approximately 17 cc., varying from about 14 cc. for women to 21 cc. for men. The children in the age group from 1¼ to 3½ years averaged approximately 4.5 cc. of water per swallow, or the equivalent of one teaspoon. The authors were impressed with the relative constancy of the ratio of volume of fluid swallowed to the body weight.

Nonrenal Humoral Hypertension

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ARTERIAL BLOOD pressure is determined by several factors. Among these are cardiac output, blood volume, blood viscosity, elasticity of the walls of large arteries and peripheral resistance of small arteries and arterioles. Hypertension is generally defined as a sustained arterial blood pressure greater than 140/90 mm. Hg.

Established diastolic hypertension may be of unknown cause; i.e., "essential hypertension." Some of the known causes are central nervous system disease, coarctation of the aorta, renal disease, adrenal disease, other endocrinopathies, toxemia of pregnancy, and porphyria.[1, 2, 3] The renin-angiotensin system will not be discussed.

The term "humoral hypertension" was coined by Prado and Dontigny in 1948[4] in the context of hypertension which follows the administration of desoxycorticosterone acetate (DOCA), pituitary extracts, and exposure to nonspecific toxins. The term will be used more loosely in this report to include hypertension related to known and suspected metabolic and endocrine disturbances. The endocrine glands known to be of significance in the establishment and maintenance of blood pressure levels include the pituitary, adrenal, thyroid, and gonad.[5]

1. PITUITARY

Removal of the pituitary in normal dogs and rats causes a fall in blood pressure. Desoxycorticosterone acetate will then return it toward normal, and corticotropin (ACTH) to normal. Corticotropin given to normal subjects will not induce hypertension, but it will elevate the blood pressure of hypertensives. Similarly, hypophysectomy will decrease the blood pressure of hypertensives by inducing adrenal insufficiency. Removal of only the posterior pituitary does not influence blood pressure, even though one of its hormones, vasopressin (Pitressin), has an antidiuretic and weak hypertensive effect.[4, 5, 6]

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2. ADRENAL

The adrenal gland is composed of two separate structures, the cortex and medulla, each of which is of significance to a discussion of humoral hypertension. Among the secretions of the adrenal contributing to blood pressure levels are the mineral corticoids, as desoxycorticosterone acetate and aldosterone, the glucocorticoids, as cortisone, and epinephrine (Adrenalin) and norepinephrine (Noradrenalin).

2a. Cortex

(1) Desoxycorticosterone acetate is produced in the zona glomerulosa of the adrenal cortex.[7] It causes a decreased urinary excretion of sodium and an increased secretion of potassium, causing an increase in plasma and extracellular volumes and a decrease in intracellular volume. When desoxycorticosterone acetate is given on a salt-free regimen, neither extracellular volume nor blood pressure increases. If given on a normal salt regimen, both increase moderately and, on a high salt diet, both increase markedly.[4, 5, 8, 9]

The hypertension that follows administration of salt and desoxycorticosterone acetate, or large amounts of salt alone in the rat, is always accompanied by renal changes.[8, 9] These changes include enlargement of the kidneys,[8] hyaline necrosis in the walls of renal arterioles and small arteries, glomerular hyalinization, and renal tubular damage.[6]

(2) Aldosterone is another salt-retaining hormone and is also secreted by the zona glomerulosa of the adrenal gland. Primary aldosteronism causes moderate blood pressure elevation whereas secondary aldosteronism does not.[10] The other major manifestations of primary aldosteronism are hypokalemia and alkalosis.[11] Other signs and symptoms include episodic or continuous weakness, sometimes even to periodic paralysis, polydipsia and nocturnal polyuria, paresthesias, and headache. Latent or manifest tetany has also been seen. Laboratory

findings include alkalosis, hypokaliemia, hypernatremia, mild proteinuria, neutral or alkaline urine of low specific gravity and large volume which is not responsive to vasopressin or water restriction.[12] This condition is due to both adrenal hyperplasia and tumor.[11] The hypertension responded to removal of the tumor or adrenalectomy in 86 per cent of reported cases.[6, 13]

(3) Hypertension is seen with prolonged increase in circulating glucocorticoids, whether it is due to a basophilic adenoma of the anterior lobe of the pituitary, adrenal tumor or hyperplasia, or exogenous hormone.[14] Continued hypercorticism causes glomerular hyalinization and disintegration,[6] and hypertension is seen in Cushing's syndrome.[10] Adrenalectomy will return the blood pressure to normotensive levels just as it will block most forms of experimental hypertension.[6] Similarly, the administration of glucocorticoids to Addisonians will restore their blood pressure to normal.[4]

(4) Others. Hypercortical conditions other than Cushing's syndrome are also associated with hypertension. Adrenal virilism is manifested by androgenic effects.[14] Testosterone itself has no direct effect upon the blood pressure, but indirectly affects it by influencing protein metabolism,[4] and the hypertension due to adrenal virilism is probably due to the simultaneous production of an abnormal cortical hormone. This theory has been confirmed by treating the condition with cortisone, causing decreased corticotropin production and secondary decrease in production of the abnormal hormone. Adrenocortical hyperfunction has also produced syndromes of virilism with some of the findings of Cushing's syndrome and these, too, may be manifested by hypertension.[5, 14]

2b. Medullary Hormones

In man, epinephrine is a vasodilator and cardiostimulating agent that may cause a fall in blood pressure. Norepinephrine is a powerful vasoconstrictor and causes hypertension by increasing peripheral resistance. Normally, the catecholamines of the adrenal gland are 80% norepinephrine and 20% epinephrine. One theory of the genesis of "essential" hypertension holds that it is caused by an imbalance of these two hormones due to an enzymatic defect in transmethylation since they differ only by a methyl group.[4]

3. OTHERS

3a. Pheochromocytoma

Pheochromocytomas are tumors whose cells are of sympathetic nervous system origin, as are the tumors of neurofibromatosis with which they are sometimes associated. Ninety per cent are found in the adrenal medulla, although they may be found anywhere in the chromaffin system, and even in the brain, chest, intestine, urinary bladder and gonads. Ten per cent are malignant, and ten per cent are bilateral or multiple. These tumors produce epinephrine and/or norepinephrine and their symptoms vary with the proportions of the two hormones secreted.[15]

The symptoms may include a sustained hypertension resembling "essential" hypertension, paroxysmal hypertension, or hypermetabolism with or without hyperglycemia and hypertension, resembling thyrotoxicosis or anxiety states.[16, 17]

Several pharmacologic tests are available to help in the diagnosis of pheochromocytoma. The phentolamine (Regitine) test is felt to be of greatest value. It is used when the blood pressure is elevated at the time, and causes a drop in blood pressure of at least 35 mm. Hg. systolic and 25 mm. Hg. diastolic if the hypertension is due to catecholamines. When the blood pressure is normal, histamine may be given intravenously, causing a brief fall in blood pressure which is followed by a rise of at least 30 mm. Hg. systolic and 20 mm. Hg. diastolic above preinjection levels. The serum or urine levels of catecholamine remain as confirmatory tests when the screening tests suggest the presence of a pheochromocytoma.[18]

3b. Carcinoid Syndrome

The carcinoid syndrome also infrequently includes hypertension as one of its manifestations. Other signs and symptoms are cyanotic flushing, diarrhea, bronchial constriction, and infrequent cardiomegaly. Fibrosis of the right side of the heart may occur, with resultant pulmonary stenosis and/or tricuspid insufficiency.[19]

The carcinoid syndrome is produced by tumors of chromaffin origin also, the active agent being 5-hydroxytryptamine, or serotonin. Such tumors have been found in the intestinal tract, most commonly in the appendix, and in the ovaries; the syndrome is also associated with malignant bronchial adenomas.[19]

Serotonin may act as a smooth muscle relaxant or constrictor, largely dependent upon the preexistent tone in that particular muscle group. Its most common effect is vasoconstriction when it is released by platelets at the site of blood coagulation.[3] It tends to cause peripheral and coronary vasodilatation, although it may induce coronary vasoconstriction; and it is also a pulmonary vasoconstrictor. The hypertension associated with the carcinoid syndrome may sometimes be reduced by antiserotonin agents, as methylserotonin or lysergic acid diethylamide.[19]

3c. Thyroid

The increased systolic pressure resulting from overactivity of the thyroid can be directly attributed to increased metabolic activity affecting cardiac output and blood flow. Thus, it is not included as a cause of hypertensive vascular disease since this means that blood pressure elevation is due to peripheral vascular constriction.[5] However, hypothyroid dogs have decreased vasoreactivity, even if given desiccated thyroid.[3]

Other reports indicate that thyroidectomy does not prevent or cure hypertension due to experimental renal artery constriction. Thyroidectomy does decrease sensitivity to corticotropin and desoxycorticosterone acetate and tends to decrease their nephrosclerotic effects.[12]

3d. Porphyria

Hypertension has been reported as one manifestation of porphyria, especially the acute intermittent form. During the acute attack, hypertension may be associated with spastic changes in the retinal arterioles, oliguria, and dark urine giving a superficial resemblance to acute glomerulonephritis. The cause of this hypertension remains unknown, but certain pyrroles do act as pressor substances. If the attack subsides and the disease becomes quiescent or latent, the blood pressure returns to normal and retinal vascular abnormalities may disappear entirely.[20, 21, 22]

3e. Toxemia of Pregnancy

Toxemia is a vague term that is basically defined by a symptom complex of hypertension, proteinuria, and edema that occurs during pregnancy. The syndrome may be associated with headache and emesis due to increased intracranial pressure that may be associated with retinopathy and coma or convulsions. It usually begins during the third trimester and terminates shortly after delivery, but in infrequent instances it has appeared to begin after delivery.[22]

The syndrome has several possible causes and must be differentiated from acute glomerulonephritis and from malignant hypertension.[22] Its causes include renal disease and pregnancy, hypertensive vascular disease and pregnancy, preeclampsia and eclampsia. The last two are different degrees of severity of the same basic process.[23] Since the development of needle biopsy of the kidney, it has been possible to delineate the cause of toxemia in the individual living patient.

The organs involved in eclampsia and preeclampsia are the kidney, liver, brain, and lung, and the blood vessels generally. The kidney is principally involved, with a characteristic glomerular lesion whose severity varies with the severity of the disease, all glomeruli being equally involved. This lesion has been found in no other renal condition. The glomerular lesion was found to precede proteinuria in even the mildest case, and to regress after delivery. The lesion persisted unchanged, even if clinical improvement occurred under medical management, until the uterus was emptied.[23, 24, 25] The exact cause of eclampsia and preeclampsia remains unknown, but one theory holds that uterine artery spasm causes placental ischemia which results in a vasoconstrictor substance being released into the circulation.[26]

The initial glomerular lesion is swelling of the endothelial cells and epithelial cells of the glomerular capillaries, with ischemia of the capillaries although they are not occluded. Slight swelling of the arterioles and small arteries is also seen. As the condition progresses, the swelling of cells and vessels worsens, glomerular ischemia progresses, the tubular cells become swollen and contain lipid vacuoles, and interstitial edema also occurs. Later the basement membrane swells, and tubular degeneration and focal interstitial fibrosis occurs. The involved vessels become sclerotic and hyaline changes occur in their walls. Until the basement membrane changes the glomerulitis may entirely recede after delivery, but once this occurs residual anatomic changes are found even in asymptomatic persons, and albuminuria may persist.[23]

Hypertensive vascular disease during pregnancy seldom is manifested by all three of the cardinal signs of toxemia. Mild retinal arteriolar spasm is sometimes seen, but the

more common finding is arteriolar thickening and tortuosity. Since the glomeruli are unchanged, renal function is not altered. Renal biopsy shows arteriolar sclerosis but no other changes, and the findings do not regress after delivery.[23]

Primary renal disease in pregnancy is frequently associated with the multiparous state, and seldom with a family history of hypertension. The cardinal signs of toxemia are frequently all found and renal function may be impaired. Renal biopsy shows the renal lesion, most commonly glomerulonephritis or pyelonephritis.[23]

The serum level of uric acid has been found to be a statistically significant and useful test in the differentiation of eclampsia and preeclampsia from hypertensive or renal disease, and also a qualitative measure of the severity of the process. The serum uric acid level varies directly with the severity of the glomerular change. The serum cholesterol, blood urea nitrogen and nonprotein nitrogen levels have been found to parallel glomerular disease but in a less reliable manner.[23]

It is of interest that vigorous medical management of preeclamptic patients, including low-salt regimen, diuretics, sedatives and hypotensive drugs, may bring about clinical improvement without changing the renal biopsy findings until after delivery occurs, the findings usually returning to normal within 10 days after delivery.[25]

It is also of interest that antihypertensive medication to previously hypertensive pregnant women may mask the onset of toxemia, but does not alter its effects as manifested by fetal size and fetal salvage.[25]

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Postinfectious Purpura

A Case Report

By ROBERT A. PRIBEK, M. D.
La Crosse, Wisconsin

PURPURA IS a recognized, though unusual, complication of an infection. It has been described following scarlatina, infectious mononucleosis, cat-scratch disease, varicella, rubella, diphtheria, mumps,[1] vaccinia, infectious hepatitis, tuberculosis, malaria, brucellosis, and an upper respiratory infection.[2, 3] The purpose of this report is to present a case of purpura which occurred after a beta hemolytic streptococcal infection and to review briefly the subject of postinfectious purpura.

CASE REPORT

A 42-year-old white housewife was admitted to the hospital on Mar. 2, 1961, because of a petechial eruption of two months duration. She became ill on Dec. 22, 1960, with fever, sore throat and dysphagia. Many beta hemolytic streptococci were found in a throat culture. Ilosone,* 250 mg. four times daily, for 10 days, produced good symptomatic response. Approximately 14 days after becoming ill, the patient first noted crops of petechiae on both lower extremities. The petechiae recurred intermittently thereafter. She had always bruised easily, but this tendency had not become more pronounced. There had been no previous petechiae. Other bleeding manifestations, fever, chills, abdominal pain, joint pain, or swelling were denied. Additional complaints were weakness, fatigue, and aching pain in the neck and shoulder regions.

She had urticaria following penicillin administration for beta hemolytic streptococcal pharyngitis one year previously. Personal and family histories were negative for other allergic disorders.

Her temperature was 99.8 F.; pulse, 90; respirations, 20; blood pressure 130/80 mm.Hg. She had several petechiae in the buccal mucosa, numerous petechiae on the upper and lower extremities, and a single moderate sized ecchymosis on the left forearm. The liver, spleen, and lymph nodes were not palpable.

Her hemoglobin level was 13 gm. per 100 ml.; hematocrit reading 39%; red blood cells 4,500,000 per cubic mm.; white blood cells 8,050 per cubic mm., with 64 segmented neutrophils, 33 lymphocytes and 3 monocytes; platelet count (Rees-Ecker) 320,000 per cubic mm.; corrected sedimentation rate (Westergren) 19 mm. per hour. Bleeding time, clotting time, clot retraction, prothrombin time, prothrombin consumption, total proteins, serum albumin, serum globulin, serological test for syphilis, blood urea nitrogen, L.E. clot test, blood cultures, and urinalysis were negative or within normal limits. A throat culture revealed a normal flora. A standard six-foot roentgenogram of the chest was normal. Inflation of a sphygomomanometer cuff to 100 mm.Hg. for five minutes (Rumpel-Leede test) produced numerous petechiae on the forearm. Bone marrow aspirate had normal granulocytic and erythrocytic maturation. Megakaryocytes were qualitatively and quantitatively normal, and adequately producing platelets.

After the completion of these studies, the patient was started on adrenal steroid therapy with prednisone in a dose of 10 mg. three times daily. The Rumpel-Leede test returned to normal three days later and there was no further bleeding into the skin or mucous membranes. Steroid therapy was continued in decreasing dosage for a period of three weeks. The patient remained well after prednisone was discontinued. Many subsequent capillary fragility tests and platelet counts were within normal limits. Three months later, a full course of Ilosone in the same dose was administered without the reappearance of purpura.

*Ilosone is the trade-mark for propionyl erythromycin ester lauryl sulfate.

COMMENT

In this case the appearance of purpura seems causally related to the antecedent beta hemolytic streptococcal infection. Admittedly, it is impossible in any individual case to prove the relationship between purpura and an infection. However, the occurrence of an episode of purpura followed by complete recovery in a patient who has never had any previous hemorrhagic symptoms and who has recently recovered from an infection, constitutes strong presumptive evidence that the purpura was due to the infection.[3] Hypersensitivity to Ilosone seems improbable as the cause of purpura in this case because a full challenge dose failed to reproduce a purpuric eruption or other hemorrhagic manifestations. At the time of preparation of this report there were no reported cases of hematopoietic toxicity due to Ilosone in the *Registry on Blood Dyscrasias* of the American Medical Association.[4] The manufacturer of this antibiotic agent has likewise received no reports of untoward effects of any type on the hematopoietic or vascular systems.[5, 6]

Purpura following infection is not a common occurrence. Box[7] was able to find only about 50 cases following scarlet fever in the literature up to 1933. Frödin[8] reported 6 cases of purpura in approximately 23,000 cases of scarlet fever; Fox and Enzer,[9] 4 cases in approximately 12,000 cases of scarlet fever; and Hunt,[10] 2 cases in 5,000 cases of scarlet fever. It occurs even less frequently after other infections.[3]

The clinical picture of postinfectious purpura is variable and bears no relation to the severity of the inciting infection.[3, 13] There may be a small number of cutaneous hemorrhages during convalescence, or a fulminating disease with extensive cutaneous and mucous membrane hemorrhages. Hematuria is especially common in the more severe cases.[3, 9] Except for the rare fatal cases, due to hemorrhage into a vital organ, the disease runs a short course and is self-limited. If recovery is not complete, or the bleeding tendency persists, the patient probably does not have true postinfectious purpura but rather a chronic purpura which has been exacerbated by the infection.[11, 12]

The latent period from the onset of the infection to the appearance of purpura varies considerably. According to Box,[7] the purpura which complicates scarlet fever has its onset most commonly in the third and fourth week, but may occur earlier or later than this. In the case herein reported there was a two-week, symptom-free period before the onset of the first crops of petechiae.

Characteristically, this variety of purpura is not exanthematous. It is true purpura: the surrounding skin is normal and shows neither hyperemia or urticaria.[3] The platelet count may be normal or decreased. The nonthrombocytopenic variety is encountered more frequently.[2, 3, 14] Anemia may result in severe cases. The white blood cell count may be normal or there may be a polymorphonuclear neutrophilic leukocytosis. In nonthrombocytopenic cases a normal bleeding time is the rule. Prolongation of the bleeding time and impairment of clot retraction occur in proportion to the degree of platelet reduction. The clotting time is usually well within normal limits in both nonthrombocytopenic and thrombocytopenic cases. Bone marrow examination may be normal, may show a reduced number of megakaryocytes with degenerative changes,[3] or hyperplasia of the megakaryocytes.[15] No significant abnormalities have been noted in the spleen in postinfectious purpura other than in cases secondary to tuberculosis.[3]

The pathogenesis of postinfectious purpura is not fully understood but it can probably best be explained on an allergic basis.[3, 13, 14, 16] A hypersensitivity factor which affects the megakaryocytes, the platelets, and the capillary walls singly or in combination seems plausible. This hypothesis is consistent with the occurrence of both nonthrombocytopenic and thrombocytopenic cases after the same infection such as scarlet fever.

Clement and Diamond,[14] in a review of a large number of cases, report an increased incidence of personal and family history of allergy among their patients. Ackroyd[3] suggests an analogy with acute glomerulonephritis, because of a symptom-free period prior to the onset of purpura. The period of maximal incidence of purpura following scarlet fever coincides with that of poststreptococcal nephritis. He further suggests that the hypersensitivity factor which can cause acute glomerulonephritis may, in another patient, produce purpura. Presumably the cases which follow a virus infection are due to a similar mechanism.

SUMMARY

A case of nonthrombocytopenic purpura occurring after a beta hemolytic streptococcal pharyngitis is reported. Adrenal steroid therapy resulted in prompt and complete recovery. The subject of postinfectious purpura is reviewed.

212 South Eleventh Street.

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one of a series

ROENTGEN RIDDLE . . .

HISTORY: A newborn infant developed increasing cyanosis, tachypnea and respiratory distress a few minutes after birth. The pregnancy and labor were uncomplicated.

PHYSICAL EXAMINATION: A 7 lb. 8 oz. infant boy with cyanosis and heart tones heard predominantly on the right were the principal findings. The obstetrician considered congenital heart disease, pulmonary hyaline membrane disease and intracranial hemorrhage as a differential diagnosis.

X-RAY: The anteroposterior radiograph revealed the entire left hemothorax to be occupied by a network of tissue densities with rounded air densities interposed. A wedge-shaped density was seen in the left upper thorax. The heart and mediastinal structures were displaced to the right. No aerated pulmonary parenchyma was seen in the left hemothorax. The abdomen was relatively airless.

DISCUSSION *on page 293*

Fig. 1—Supine radiograph of the chest and abdamen.

Role of Occupational Therapy in the Care of the Aged

By MISS MARILYN HENNESSY, O. T. R.
Madison, Wisconsin

AS THE NUMBER and proportion of persons in the older age groups have increased, the need for services and personnel to meet the concomitant rise in chronic disease and disability has also increased. There has been a particular demand for greater numbers of occupational therapists and other paramedical personnel. It becomes important, then, for these personnel to define their roles as members of the treatment team.

The role of occupational therapy in the care of the geriatric patient derives from the aging process itself. It is a form of treatment prescribed and guided by a physician which utilizes the physical, psychological, and social factors embodied in activities. The three-fold purpose of treatment includes: (1) achievement and maintenance of maximum physical potential, (2) development of latent talents, interests, and capabilities, and (3) reestablishment of the ability to develop interpersonal relationships. The ultimate objective, of course, is the maintenance or return of an individual to his maximum level of function.

Physical changes and onset of disability often limit the abilities of the older patient to the point of dependence in self-care. To help him regain independence in activities of daily living, the therapist first evaluates his current function, then provides necessary adapted equipment, and finally trains him in methods of independent function. These selected, graded activities of occupational therapy result in improvements in range of motion, muscle strength, coordination, and tolerance.

The older person needs an interest or responsibility that will give him some degree of status and a feeling of being useful. Since ours is a work-oriented society, the aging individual is frequently deprived of this all-important source of self-expression, so he must find a substitute. Occupational therapy can help him discover latent interests and abilities and use them meaningfully.

Love, companionship, a sense of participation and belonging are essential to geriatric patients. Many of them have lost family and friends, and have had little opportunity to make new friends. Thus, they may experience feelings of inadequacy and loneliness. Planned group activities including recreation, handicraft, and educational work can aid them in regaining the ability to develop effective interpersonal relationships. However, these activities must be planned so that the skills developed are directly related to the environment and ultimate goal of the individual patient. Each one must become an active participant.

Occupational therapy has long been recognized and used with geriatric patients as a treatment in the multidiscipline approach of the rehabilitation center and hospital. As special facilities and programs for the care of the aged emerge, new settings for occupational therapy follow. Many nursing homes and homes for the aged are using occupational therapy effectively to improve the functional level of dependent patients and to prevent mental and physical deterioration in well residents. Some public health agencies and hospitals are providing occupational therapy to homebound patients in coordinated after-care programs. Recently, state health departments have engaged occupational therapists to function in an educational capacity.

The Division of Chronic Disease and Aging of the State Board of Health has two occupational therapy consultants. Working together with consultants in nursing, physical therapy, speech and hearing, and social work, they prepare educational programs in rehabilitative nursing for nursing personnel of hospitals, nursing homes, and public health agencies throughout the state. The occupational therapists teach techniques of self-help, demonstrate adapted equipment and its

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use, and present activities designed to help maintain optimal levels of function. Also, the consultants are available to the participating agencies for individual patient evaluation and rehabilitative nursing instruction, upon the request, and with the prescription, of the patient's physician. The suggested programs are carried out by the nurse, and the therapists are available for reevaluation when it is indicated.

The consultants in occupational therapy also assist nursing homes to establish planned activity programs for their patients. Program planning, training of staff and volunteer personnel, and continuing consultation are among the services provided.

The role of occupational therapy in the care of the aged remains constant even though the setting changes. The aim is still the achievement of maximum physical potential, development of latent abilities, and improvement of interpersonal relationships—in short, the return of the geriatric patient to his maximum level of function.

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ROENTGEN RIDDLE *continued from page 291*

DISCUSSION: The radiographic findings represent a herniation of many air-filled loops of intestine into the left thorax with atelectasis of the left lung and shift of the mediastinal contents to the right.

Congenital diaphragmatic hernias are not common, but the obstetrician is to consider the possibility with newborn cyanosis since a pediatric surgical emergency may exist.

Congenital diaphragmatic hernias most commonly occur through a defect in the posterior aspect of the diaphragm. Further it is five times more common on the left than on the right. Also called the pleuroperitoneal hiatus or foramen of Bochdalek, this defect is said to represent a failure of fusion of pleuroperitoneal membrane which normally occurs about the eighth week of embryonic life. Complete absence of the left hemidiaphragm has also been reported. Other sites for congenital hernia include the anterior foramen of Morgagni, the right hemidiaphragm and the esophageal hiatus. Extremely rare is the esophageal hiatus hernia with a congenitally short esophagus.

Clinically, congenital cardiac disease is suspected because of cyanosis, tachycardia and respiratory distress. The amount of intestinal contents in the thorax is considerable in these cases. Less severe cases may present as early feeding problems, incomplete or complete intestinal obstruction or intestinal strangulation. Abnormal positions of the cardiac sounds and audible peristalsis in the chest completes the clinical picture.

Conclusive diagnosis is readily made roentgenographically, usually without the aid of contrast medium. Routine films reveal multiple loops of intestine in the thorax, mediastinal shift, compression of the lung on the involved side and a paucity of gas within the abdomen. Upright films may reveal air fluid levels within the bowel if there is an associated intestinal obstruction. The size of the defect cannot generally be estimated roentgenographically and is apparently of no surgical significance. Contrast studies of the intestinal tract will rule out a congenitally short esophagus or reveal those cases which have obscure unidentifiable densities in the lower thorax that represent airless herniated bowel. The differential diagnosis radiographically is not difficult when the amount of herniated contents into the thorax is great.

TREATMENT: When the disorder is severe enough to produce cyanosis or intestinal obstruction, a pediatric surgical emergency exists. Less severe cases are evaluated on clinical grounds.

CONCLUSION: Congenital diaphragmatic hernia should be considered in cases of newborn cyanosis or respiratory distress. Less severe cases may present to the pediatrician only as a feeding problem. X-ray examination of the chest is conclusive in most instances. The disorder represents one of the severe congenital anomalies which can be cured and not just palliated.

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Vasodilator Drugs

By HAROLD F. HARDMAN, M. D., Ph. D.
Milwaukee, Wisconsin

BY DEFINITION, vasodilator drugs are chemical agents that dilate blood vessels. Specifically these drugs produce relaxation of vascular smooth muscle. From a clinical standpoint our major interest in these agents has been directed toward the arterial vascular bed. It is only in recent years that we have become aware of their effect upon venous vascular beds. The hypotension following administration of nitroglycerin is primarily a systolic hypotension with less effect upon diastolic blood pressure. The reduction in systolic blood pressure is a reflection of reduced cardiac output which is best explained by a decrease in venous return to the heart since nitroglycerin does not directly depress force of myocardial contraction. This interpretation suggests that venous pooling results from an action of the drug upon venous vascular smooth muscle. The hypotensive response to nitroglycerin is immediately opposed by sympathetic reflexes originating in the baroreceptors of the aortic arch and carotid bifurcation. In general, the compensatory sympathetic vasoconstriction is most effective upon the arterial vascular system and less effective on the venous system because of the poorer sympathetic innervation to the veins. The end result is a greater decrease in systolic pressure than diastolic pressure.

There are two major types of arterial blood vessels in the body. Those vessels found in skin appear to differ from those found in muscle beds in their response to drugs. Epinephrine produces vasodilatation in resting muscle whereas vasoconstriction represents its major action in skin vessels. Clinically employed vasodilator agents such as nylidrin and tolazoline also demonstrate selective vasodilator activity for muscle and skin vessels respectively. Regional as well as organ (skin and muscle) specificity exists for vasodilator agents. It is generally accepted that the nitrites and organic nitrates have a preferential action upon coronary vascular smooth muscle when employed in minimally effective doses.

Drugs may relax vascular smooth muscle and produce vasodilatation either by a direct action upon the vessels or by interfering with the sympathetic innervation of these vessels. This indirect effect may originate at cortical levels (barbiturates), hypothalamus (dihydroergotamine), sympathetic ganglia (mecamylamine, chlorisondamine), or postganglionic adrenergic receptor organs (tolazoline, azapetine). The indirect acting drugs would be expected to increase blood flow primarily in those areas where high tonic sympathetic activity was a major factor in controlling vascular resistance. This is observed in skin and mesenteric blood vessels. The blood vessels in muscle beds have relatively few sympathetic fibers so that sympathectomy or chemical interference with sympathetic transmission produces little change in muscle blood flow. Direct acting vasodilators are generally more effective in treating peripheral vascular diseases in which increased sympathetic nerve activity is of secondary importance. Nylidrin and isoxsuprine are representatives of this class and are employed for intermittent claudication, ischemic night cramps and muscle atrophy on the rational basis that they increase muscle blood flow.[1]

The mechanism by which coronary vasodilator agents provide relief in angina pectoris is by no means understood. For many years the hypothesis that increased blood flow to the myocardium provides needed oxygen to an ischemic myocardium to antagonize anginal pain has been accepted as the mechanism for the therapeutic action of nitroglycerin. Recent reviews[2, 3] indicate

that increased force of myocardial contraction is often related to the onset of angina pectoris. By contrast increased heart size, heart rate or blood pressure require more oxygen than increased contractile force and these changes do not necessarily precipitate an anginal attack. The myocardium cannot withstand an oxygen debt, and hypoxia is a more potent vasodilator agent than any known drug. It is quite possible that the primary action by which most coronary vasodilator agents improve myocardial ischemia is related to a reduction in the metabolic demands of the myocardium.

Sufficient evidence is available to indicate that long-term nitrite therapy increases the size and extent of intercoronary collateral vessels. This evidence plus clinical experience have established nitroglycerin as a drug of choice in angina pectoris even if its mechanism of action remains a mystery.

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THE RISK OF INTERRUPTING LONG-TERM ANTICOAGULANT TREATMENT

Sise, Herbert S., et al., Boston City Hospital, and Tufts University School of Medicine, Boston, Mass., *Circulation* 24: 1137 (Nov.) 1961.

The results of interrupting long-term anticoagulant treatment in 136 instances in a total of 310 patients are presented. It is shown that following cessation of therapeutically induced bleeding a hypercoagulable state follows, with a resulting increase in thrombo-embolic complications.

The 310 patients were divided into three groups. Group A consisted of 43 patients in whom treatment was interrupted because of bleeding. In this group there were 45 instances in which: (1) treatment was interrupted for three days or more, (2) vitamin K_1 was given in a dose large enough to return the prothrombin time to normal, or (3) the patient had to be given a blood transfusion.

Group B included 52 patients in whom treatment was stopped permanently for various reasons before the end of the period for which treatment had been planned.

Group C consisted of 28 patients who stopped treatment temporarily in 38 instances for reasons other than bleeding.

Thrombo-embolic complications were considered to have occurred if the conditions seemed to justify this conclusion. Death was considered to be due to a vascular disorder unless the circumstances clearly indicated that it was not.

The three groups were similar with regard to age distribution and the incidence of diabetes and hypertension, but groups A and B were closely comparable in every respect while group C was not; for this reason, group C was dropped from comparison after a few preliminary observations. In group A there were 10 fatal and 10 nonfatal complications. Of these 20, 14 occurred within four weeks of stopping treatment. A rebound effect is suggested to account for the significantly higher incidence than in the other groups. In group B there were 7 fatal and 8 nonfatal complications and of these, only one occurred within the first four weeks. In group C there were only 3 complications, all nonfatal. Further comparison between groups A and B failed to indicate that the high incidence of early complications in group A could be accounted for on the basis of any difference in the composition of the two groups. By careful analysis the transfusion of banked blood, administration of vitamin K_1 and secondary ischemia initiating a series of events culminating in thrombus formation were all ruled out as factors responsible for the difference between the two groups. Source of bleeding did not appear to be significant, since fatal complications occurred even after minor bleeding.

Results of this study suggest that a hypercoagulable state is induced as a direct result of anticoagulant-induced bleeding. The mechanism responsible for this state is not clear. Attention is drawn to the fact that bleeding during anticoagulant therapy is a more undesirable complication than is generally appreciated and that in addition to hemorrhage there is a very real risk of triggering a possibly fatal rebound phenomenon.

The total mortality rate from anticoagulant therapy is estimated at 2.6 per cent. The fact that this figure compares with that for many surgical procedures indicates the need for cautious use of anticoagulants.

The study suggests that interruption for reasons other than bleeding does not lead to early complications and that the risk of interruption for relatively short periods is small.—*International Medical Digest*, Vol. 78; March, 1962.

The New President

NELS ALFRED HILL, M.D.

The newly installed president of the State Medical Society, Nels Alfred Hill, M.D., received a B.S. degree in animal nutrition from Iowa State University in 1923, an M.S. degree in genetics and biological chemistry from the University of Wisconsin in 1924, and his M.D. degree from Harvard Medical School in 1929. He was born in Williams, Iowa, Nov. 22, 1901. He interned and took his residency at University Hospitals, Madison, and then served as a Fellow in Medicine at the Lahey Clinic, Boston.

For the past 30 years, Doctor Hill has been engaged in private practice in Madison as internist and cardiologist. For 25 years he was associated with the University of Wisconsin Medical School as instructor in clinical medicine and as preceptor. His teaching also included instruction in the Nursing Schools at St. Mary's Hospital and Madison General Hospital. He has served as chief of the medical staff and chief of staff at Madison General Hospital.

Doctor Hill's interest in the Dane County Medical Society and the State Medical Society has been continuous since serving as vice-president and president of the county organization. From 1953 to 1961 he acted as councilor from the third district. He was treasurer of Wisconsin Physicians Service and assistant treasurer of the State Medical Society, as well as a member of the executive committee of the Council and treasurer of the building committee.

Presently, Doctor Hill is medical director for Wisconsin Life Insurance Company and is the local surgeon for the Illinois Central Railroad in addition to his private practice.

As an advocate of increasing medical knowledge through participation in medical programs, he is secretary and trustee of the Interstate Postgraduate Medical Assembly and a member of the American Diabetes Association, American Geriatrics Society, Wisconsin and American Heart Association and Wisconsin Society of Internal Medicine.

In civic affairs, he has given generously of his time to the Arthritis Foundation, Community Welfare Council, the Red Cross, United Givers, and the Family Welfare Association. He belongs to Phi Sigma, Phi Beta Pi, the Optimist Club, Madison Club and the West Side Business Men's Club.

He lives with his wife in Madison.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Toxic Morsels

THE NEW FEDERAL law requiring hazardous household products to be labelled to protect users and to warn of dangers to children realistically updates the coverage of the first Federal Caustic Poison Act, passed 30 years ago. With the vast proliferation of household aids to the busy homemaker, it is essential that some warning be given the user as to the dangerous character of some of them.

Now for the first time, all household substances or products that could cause human injury or illness as a result of any foreseeable application, including ingestion by children, must bear a signal word on the label, as well as the statement "Keep Out of the Reach of Children." Hazardous substances include paints, solvents, petroleum products, polishes, bleaches, cleaners and many other products commonly used in the home.

While the Federal Hazardous Substances Labeling Act is a step in the right direction, the most it can do is force manufacturers and distributors to label their products properly. It cannot force users of hazardous substances to read the labels, nor can it actually keep hazardous substances out of the hands of children. The information which the law now provides must be made important to parents and others charged with the responsibility for youngsters, and this is the area where a little extra effort by the physician can make the law truly effective.

Mothers of small children should be repeatedly reminded to read labels and heed their warnings. Parents should be alerted to the dangers of the household products in constant use, and their obligation to make use of the information that the law requires be made available to them.

Nobody can protect a fool from his folly, but we would be remiss in our duty if we didn't make a conscientious attempt to do so. A word of warning, a friendly hint dropped here and there may forestall a parlous session with a stomach pump—or worse. Tell your patients to read labels and remember what they read.

The warning ignored may be an invitation to disaster.

—D. N. G.

Special to the Journal

Public Health Services and Their Functions

EDITOR'S NOTE: Dr. Frank Urban, Green Bay health commissioner, addressed a committee of the League of Women Voters in the home of Mrs. Robert T. Schmidt at Allouez on March 20, 1962. The following remarks he made concerning a county-wide public health department are informative and should be of general interest.

LET ME BRING you the greetings and good wishes of the Green Bay Board of Health. You are contemplating the establishment of complete public health services in Brown County outside of the City of Green Bay. The City of Green Bay already has a fine Health Department for which full credit should be given to the founders, Drs. A. J. McCarey and George M. Shinners. This statement is not meant to be criticism of the rudimentary Brown County Health Department. The county nurses, Miss Mary Norton and Mrs. V. G. Devroy, have given excellent and devoted services to the County. But now you are thinking in terms of *complete* public health services.

Your thinking is sound, for complete public health services are a valuable asset to a community. Let me briefly sketch the composition of a complete health department: medical health officer and staff, laboratory, sanitation, public health nursing, vital statistics, clerical and business.

Everyone knows, speaking in military terms, that the artillery cannot wage a war. Nor can the infantry fight a war. All of the various branches constitute a complete army. But even a complete army cannot wage a winning war. A gifted general is needed to direct the army.

In terms of public health, the medical health officer has a very great responsibility. He should be a storehouse of medical and scientific knowledge; *he* blows the breath of life into a health department. Every day of the year, his knowledge is tested. A safe milk program, a safe water program, a safe meat program do not constitute a health department. They are only parts of the whole.

The objective of a health department is man and his environment.

The public health department is an asset to a community—

(1) because it extends the average life span, in cooperation with the medical profession, and because it helps us to make a living. The proof: during the last half century, the average life span has almost doubled, due to the application of preventive medicine. Epidemics have largely disappeared and living conditions, under public health, have become pleasant.

(2) On the other hand, as Doctor Anderson, dean of the University of Minnesota School of Public Health, pointed out it is not so well known that public health *pays*. How much cheaper, he points out, to prevent the complications of syphilis than to treat them in public institutions. How much cheaper to prevent whooping cough, lockjaw, diphtheria, smallpox, typhoid, food poisoning, etc., than to treat such cases. The rat control program has saved millions of dollars in Baltimore, besides eliminating the spread of diseases carried by rats.

(3) There is another economic aspect of a public health department which has recently been discovered by a joint research by the Bloomington, Ill., "Pantograph" and the University of Illinois. The research produced the remarkable finding that the prosperity of the greater Bloomington trading area rested on two pillars—good schools and good public health. It seems reasonable to assume that the extension of public health to the county, outside of Green Bay, will produce greater prosperity.

You, the people of Allouez, are a living testimonial of the prosperity of the City of Green Bay.

Let me also mention, that it is not unusual for the Green Bay health commissioner to be consulted by local industries on problems having both a public health and economic composition. Every such query is a challenge which tests his knowledge.

I suppose the logical way for you to proceed is to approach the people of Brown County, outside of the city limits, and invite their support for the expansion of the Brown County Health Department. Explain to the people of the county what public health is and what it can do for them. Once that is done, you will have one of two choices. You may either decide to have your own county health department, or to amalgamate with the city in a City-County Health Department. If the latter should be a choice, rest assured that the Green Bay Board of Health will welcome you. Unfortunately due to lack of additional resources, the Green Bay Board of Health and the Green Bay Health Department are unable to participate in your campaign to sell complete public health to the county. You have our best wishes.

THE MEDICAL FORUM

Physicians' Judgment is Key To Recent Changes In W.I.A.A. "Days-Out" Regulations

Society Building Addition Progresses Steadily

Shown above is a view of the new addition to the State Medical Society building in Madison taken from the Lakeside Street approach. Designed to provide an additional 18,000 square feet of space, the new wing will make it possible to house the 45 employees of the underwriting and accounting departments of the State Medical Society, which are currently located in a branch building, under the same roof with all other departments of the Society.

Tentative date for occupancy of the new addition is sometime in November. When ground was broken in mid-December of 1961, it was anticipated that the moving date would be about the middle of October. A 5-weeks' teamsters' strike, however, caused a considerable setback to the work which up to that time had been progressing even more speedily than had been scheduled.

All structural steel, which was to have been in place by May 1, was completed well ahead of schedule. During the month of May, all floors will be poured and the outside brick work started.

Shown opposite is a lakefront view of the new addition.

Earlier Starting Date For School Physicals

Several important changes, including major revision of the "days-out" regulations which govern return to competition of an injured athlete, have been announced by the Board of Control of the Wisconsin Interscholastic Athletic Association.

Effective next fall, athletes who sustain minor injuries, including some minor fractures, will be required to stay out of competition for as long as is indicated by the attending physician.

Present rules require three days or more sidelining depending upon the seriousness of the injury.

Change in the "days-out" regulations came after a meeting with the Subcommittee Advisory to the W.I.A.A. of the State Medical Society's Division on School Health of the Commission on State Departments early in April.

"While a minimum 'days-out' regulation will continue in effect for all but the minor injuries, the brunt of the responsibility for determining readiness to resume activity now will rest with the doctors treating the athlete," said John Roberts, executive secretary of the W.I.A.A.

The regulations apply to the association's Benefit Plan, an insurance-type program designed to help defray the costs of treatment for athletic injuries. Athletes must comply with the rules governing return to competition or benefit payments for physicians' fees will not be made.

(Continued on page 300)

W.I.A.A. "Days-Out" Regulations

(Continued from page 299)

Changing of the regulations necessitated use of a new certificate on which the physician indicates the earliest date of return to competition. The certificate will be brought to the physician and returned to the school by the athlete.

The W.I.A.A. also pointed out that the "days-out" rules do not prohibit conditioning activity for the injured athlete during the restricted period.

In other action, the Board of Control:

1. Increased from 10 days to 20 days, or from $100 to $200, the maximum charges payable for hospitalization in the Scheduled Program.
2. Moved up the earliest possible date for physical examinations from August 1 to July 1.
3. Increased the plan fees charged to schools covered in the Special Group Athletic division by 10 per cent. This is an unscheduled program of coverage which experienced a loss during the past year.

"Days-Out" Regulations

(Effective for Fall of 1962)

Type of Injury	Days-Out Requirement
a. All minor injuries such as contusions, cuts, sprains (except where knee ligaments are involved), aspirations, etc.	See Doctor's Certificate
b. All minor fractures or dislocations of bones in nose, hand, foot, finger, toe and involving ribs	See Doctor's Certificate
c. Fractures involving bones other than those specified in (b) above	See Doctor's Certificate-Minimum-30 days
d. Dislocation or separation of joint, such as in shoulder	See Doctor's Certificate-Minimum-15 days
e. Any type of injury to the knee involving menisci (cartilage) or ligaments	See Doctor's Certificate-Minimum-15 days
f. Contusions to the kidney	See Doctor's Certificate-Minimum-30 days
g. Ruptured visci i.e. spleen, kidney, liver and other internal organs	See Doctor's Certificate-Minimum-60 days
h. Minor concussions, including fleeting loss of consciousness	See Doctor's Certificate-Minimum-6 days
i. Skull and intracranial injuries (fractures, subdural hematoma, etc.), including all major concussions not applicable in (g) above	See Doctor's Certificate-Minimum-30 days

The Executive Committee and the medical advisor of the benefit plan have the authority to enforce more stringent limitations if deemed advisable by voiding claims involving repeated injury to the same body part.

Treatment expense incurred after the athlete returns to practice or competition following injury will not be compensable unless evidence acceptable to the executive committee and medical advisor is provided which justifies such treatment.

Guaranteed-for-life Insurance Policies Show Rapid Increase

The number of guaranteed-for-life health insurance policies and plans available to persons in or near retirement is increasing at a rapid rate, the Health Insurance Institute reports.

The Institute in July 1961 reported 126 guaranteed-for-life plans and policies available for the aged. The policies were provided by 66 different companies.

Developments in this area have been so rapid, the Institute reports, that as of January 1962 there was a 25 per cent increase in the number of policies offered in this field. At that time 81 insurance companies were providing a total of 157 policies and plans that are guaranteed for life.

Many of the policies reported are available to any one 65 years of age or older regardless of physical condition. Some of the policies accept new applicants up to age 80 or older, and some group-type plans enroll people 100 or older. Some of the policies, which become paid up for life at age 65, are designed for persons under 65.

The Institute said all of the policies have a lifetime guarantee, which means the insured person paying his premium retains his coverage regardless of how his health may change. The HII added that protection enrolled in the group-type plans cannot be terminated by the insurance company for any individual policyholder—only for residents of an entire state as a group.

MARCH MEDICARE FIGURES

Wisconsin physicians treated 614 cases under Medicare, the government program for dependents of servicemen, during March. Total payments reached $43,702.

SAFETY PATROL SENDS 400 TO WASHINGTON, D. C.

Some 400 Wisconsin boys and girls and their chaperones joined more than 30,000 of their counterparts from 25 states and the District of Columbia in Washington, D. C. early in May for the 26th annual AAA School Safety Patrol Assembly and Parade.

B. A. Precourt, safety director for the American Automobile Association Wisconsin Division, stated that since 1922, when the patrol program was launched, the traffic fatality rate of children between 5 and 14 years of age has dropped nearly one-half and the efforts of safety patrols have been responsible for a substantial part of this reduction.

Physicians Requested To Use New Forms; Medicare Claims

Physicians rendering care to dependents of servicemen, particularly those on duty with the 32nd Division, will be interested in the following information on the Medicare program:

1. The Federal program is administered, for physicians' services in Wisconsin, by the State Medical Society.
2. Payments must be made in accordance with the program's established regulations if the State Medical Society is to receive reimbursement for claims payments made.
3. Medicare provisions do not allow payments to be made for services received or charges incurred either prior to the sponsor's entry into active duty or after his discharge from service. This includes the components of complete obstetrical care—prenatal, delivery and postpartum care.

"Completion of claim forms showing the dates, when applicable, and reporting only charges incurred during the sponsor's active duty period will help insure that the patient receives the benefit of the full payment to which the program entitles them," stated R. E. Koenig, Medicare director for the Society.

Inclusion of the dates of entry on active duty and discharge will also eliminate additional correspondence between the physician and the Society, he added.

A new form (1863-2), buff colored, has been designed to furnish more adequate information. Physicians are requested to contact the Society for supplies of the new form and discard any remaining supply of the obsolete white-colored form.

Rumble Strips Contribute to Traffic Safety

"Noisy roads"—otherwise known as rumble strips—have proved to be a definite contribution to traffic safety in tests carried on in several sections of the country, according to B. A. Precourt, safety director for the American Automobile Association Wisconsin Division.

They are made by putting small stones into the pavement which produce a distinct change in tone of the tires on the highway, and this serves to alert the driver that he is entering a zone of unusual hazard. They have been tested both in Illinois and California and results show a reduction in accidents. The California experiment led the scientists to conclude that the strong stimuli to slow down, produced by the rumble strips, is especially important where other distractions are present, when boredom and fatigue exist, after long stretches of easy driving. In the Illinois experiment, observance of a stoplight was greatly increased when rumble strips were installed.

MEDICAL MUSEUM FILM AVAILABLE

A 16mm. black and white film of about seven minutes duration on the Museum of Medical Progress is now available for use at county medical society and auxiliary meetings.

The film, developed by the State Medical Society and the State Historical Society of Wisconsin, has been provided to all television stations in the state.

Also available is a series of 35mm. colored slides on the museum and an accompanying script which constitute a program of about 30 minutes duration.

All are available from: State Medical Society, 330 East Lakeside Street, Madison, Wis.

Prematurity Institute

About 70 physicians and nurses attended an institute on the care of the premature infant at Appleton Memorial Hospital April 11. The institute was sponsored by the State Medical Society's Charitable, Educational and Scientific Foundation and the Bureau of Maternal and Child Health of the State Board of Health.

FUTURE NURSES CLUBS HOLD MEDICAL CAREERS DAY IN APPLETON

Representatives from five colleges and universities, eight schools of nursing, and four professional organizations participated in the Medical Careers Day sponsored by the Future Nurses Clubs of the three Appleton high schools April 10 at Xavier High School. The special event was planned so that parents could confer with the school representatives with their sons and daughters. Careers in pharmacy, nursing, medicine, dentistry, medical technology, physical and occupational therapy, dietetics, speech therapy, psychology, psychometric testing and psychiatric social work were discussed.

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Racine Journal-Times Photo

THE NUMBER OF COUNTY MEDICAL SOCIETIES who have developed their own individual seals is steadily increasing. Racine, Kenosha, Fond du Lac, Douglas and Crawford are the latest county societies to have designs. The Racine County Medical Society obtained its new design through a contest conducted for local art students. The top three designs were awarded prizes. The Racine seal is shown above being held by Dr. Joseph D. Postorino who congratulated the top three winners. The winning seal was designed by Ray Krenzke, shown above on the right. The Kenosha, Fond du Lac, Douglas and Crawford seals are shown below.

Increased Use of Mental Health Clinic Cited in Waukesha

The mental health clinic, one of Waukesha county's youngest departments, had a patient increase of almost 100 per cent during 1961, according to its director, Dr. John R. Altmeyer. The department handled 465 cases or families in 1961 compared with 287 in 1960. In addition 202 persons received active treatment on a continuing basis for the year as compared with 97 for the previous year.

Dodge County Auxiliary Voices Opposition To King-Anderson Measure

The Woman's Auxiliary to the Dodge County Medical Society in April passed a resolution opposing the King-Anderson bill. The resolution, forwarded to representatives in Congress, reads:

"Whereas, the 87th Congress of the United States is now considering H.R. 4222 and S. 909, a bill to provide for certain medical services to the aged, financed through Social Security benefits and

"Whereas, upon careful scrutiny of this proposed legislation we have determined that:

1. There is no need for such a bill,
2. The majority of our senior citizens are financially independent and are not physically disabled,
3. Help would be given where it is not needed,
4. Future generations would be saddled by the staggering costs, and
5. Would produce a system which would inevitably result in the deterioration of medical care as it has in other countries.

"Now therefore, be it resolved that we, the members of the Woman's Auxiliary to the Dodge County Medical Society, oppose the enactment of said bill and,

"Be it resolved further, that copies of this resolution be sent to our congressman, Robert Kastenmeier and to Senators Alexander Wiley and William Proxmire."

Cited For Civic Service

Dr. William Schultz has been cited for the service he gave over the past 12 years as a member of the Jefferson county school committee. He resigned April 1 as chairman of the committee.

RACINE SOCIETY HELPS SCOUTS

To help Racine Boy Scouts recognize what is poisonous and to teach them what to do when poison is swallowed, Sister Mary Incarnata at St. Mary's Hospital, Racine, has prepared a 12-page pamphlet on toxicology which the Racine County Medical Society is distributing. The county society also is considering a printing for mass distribution in the city.

Teamwork and Fast Action Save Two Lives; Poisonings

Without the new poison control center in Memorial Hospital at Neillsville the time required to gather information about the poison taken and its antidote may have proved fatal for a year and one-half-old Chili girl. Rose Marie Pescinski was brought to Memorial Hospital suffering from the effects of taking an aphid and mite insecticide containing an unusual poison. Knowing the name of the insecticide, the poison control center determined the poisonous agent and its specific antidote in a matter of two or three minutes. The girl's parents were credited by Dr. T. N. **Thompson**, Neillsville, with forethought for bringing with them the container of material from which the child had taken the poison.

In Iola, one-year-old Tami Gunderson swallowed ant poison containing arsenic. She was rushed to the Iola Hospital where Dr. Robert **Buxbaum** treated her and phoned St. Michael's Hospital at Stevens Point for a special antidote to counteract arsenic. Two ampules containing the antidote were raced to the hospital by Portage and Waupaca county deputies. Little Tami can be doubly thankful about the outcome of her experience because Doctor Buxbaum was available for treating her through the efforts of the State Medical Society's Placement Service which arranged for Doctor Buxbaum to assist the community in its medical emergency following the death of its only two physicians. Doctor Buxbaum is a resident in internal medicine at University Hospitals in Madison.

Rural Health Conference May 18–19, Des Moines, Ia.

The Third Regional Rural Health Conference of the American Medical Association was held May 18–19, 1962, at Hotel Savery, Des Moines, Iowa.

All interested physicians and others associated with rural health problems were invited to attend.

The State Medical Society was represented at the conference by the chairman of its Commission on Public Relations and Communication, Dr. D. E. Dorchester of Sturgeon Bay.

COURSES IN MASS CASUALTIES MANAGEMENT

Physicians interested in attending postgraduate short courses on "Management of Mass Casualties" may arrange with the American Medical Association for attendance according to the following schedule:

October 8–12, 1962
Medical Field Service School
Brooke Army Medical Center
Fort Sam Houston, Texas

October 30–November 1, 1962
Walter Reed Army Institute of Research, Washington 12, D. C.

March 25–29, 1963
Medical Field Service School
Brooke Army Medical Center
Fort Sam Houston, Texas

Physicians interested should write to the AMA Department of National Security, 535 North Dearborn Street, Chicago 10, Illinois.

Other Wisconsin representation was expected on the part of the Agricultural Extension Service, Wisconsin State Grange, Wisconsin Farm Bureau, State Board of Health and other allied organizations.

Among the topics for discussion were quackery, animal diseases that endanger human health, poison dangers on the farm, health insurance, student medical loan programs, and medical self-help training.

Federal FDA Discounts "Calories Don't Count"

The Food and Drug Administration announced two seizures of safflower oil products with copies of the diet book, "Calories Don't Count," in April on charges of false reducing and health claims. They were the third and fourth seizures to include the book as the source of false and misleading claims for safflower oil. Copies of "Calories Don't Count," by Herman Taller, M.D., obstetrician and gynecologist, were seized last January in two actions in New York City charging they were being used to represent falsely that safflower oil capsules are effective for weight control without regard to total caloric intake.

LEGAL–MEDICAL CLINIC AT MARSHFIELD APR. 7

Approximately 60 attorneys, insurance adjusters and physicians attended the Third Annual Legal-Medical Clinic conducted by the Marshfield Clinic Foundation for Education and Research at Marshfield on April 7.

Edward F. Zappen, Marshfield, a member of the State Bar of Wisconsin's Committee on Postgraduate Education, sponsoring organization, said the purpose of the session was to give attorneys in the area essential information on such subjects as lung deficiencies, evaluation of injuries, the use of the electroencephalograph in medical-legal problems, the cause, control and treatment of staphylococcal infections, injuries of the brain, resuscitation methods, and lawyer-doctor preparation for testimony at a trial.

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River Falls Votes for Fluoridation

The physicians of River Falls, Wisconsin, played a prominent role in the successful campaign to fluoridate the local public water supply. As with most referenda on this subject, feelings ran high. But when the votes were counted on April 3, the people of River Falls had decided they wanted fluoridation.

Here is a sample of the kind of publicity developed by the River Falls physicians during the campaign:

To the Editor:

The stand of your doctor in regards to the matter of fluoridation is a firm and positive "Yes". Along with other health authorities we can only urge the acceptance of this measure as a step for progress in our community.

The members of a small Texas community with a high natural fluoride content discovered that their teeth did not decay nearly so fast as the average community. Since this time, many controlled studies have provided "irrefutable evidence" that fluoridation of drinking water is safe and effective.

Safety and effectiveness is attested to by the endorsement by such groups as the U. S. Public Health Service, the American Medical Association, the American Dental Association, and your own State Board of Health, plus scores of others.

It is expected that the "anti-fluoridationists" will bring many derogatory allegations using typical "scare tactics". Please evaluate these accusations in the light of the facts before you vote April 3rd.

Sincerely,

F. O. GRASSL, M.D.
P. H. GUTZLER, M.D.
R. H. HAMMER, M.D.
P. S. HASKINS, M.D.

DISCUSS SCHOOL HEALTH

Representatives of the Green County Medical Society took part April 6 in a luncheon meeting for school administrators in the county on school health.

Tentative school health policies were reviewed by representatives of the medical and dental societies and the county nurse.

GOVERNOR GAYLORD NELSON IS SHOWN with Donna De Young, student nurse at Methodist Hospital School of Nursing, Madison, and Martin H. Albrecht, assistant superintendent, University Hospitals, Madison, and president of the Wisconsin Hospital Association, when he recently signed a Proclamation designating May 6–12, 1962, as National Hospital Week in Wisconsin. Theme of this year's observance is "Your Hospital—Uniting Science and Patient Care." The proclamation appears on the following page.

Announce Officers, Wisconsin Hospital Association, 1962-63

Officers of the Wisconsin Hospital Association for 1962–63 were announced at the recent annual meeting of the association in Milwaukee.

They are M. H. Albrecht, assistant superintendent, University Hospitals, Madison, president; Harold C. Guntner, administrator, Memorial Hospital, Menomonie, president-elect; N. E. Hanshus, administrator, Luther Hospital, Eau Claire, immediate past president; Robert M. Jones, administrator, Waukesha Memorial Hospital, Waukesha, first vice-president; Mrs. Berenice I. Elliott, administrator, Kaukauna Community Hospital, Kaukauna, second vice-president; Earl G. Dresser, administrator, Methodist Hospital, Madison, treasurer; and Warren R. Von Ehren, Madison, executive director.

Trustees are T. E. Besser, administrator, Hudson Memorial Hospital, Hudson; R. J. Platte, administrator, Clintonville Community Hospital, Clintonville; Sister Mary Vincent, administrator, St. Catherine's Hospital, Kenosha; John R. Temte, administrator, Memorial Hospital, Neillsville; Edward J. Logan, administrator, Milwaukee Children's Hospital, Milwaukee; O. H. Guenther, director, Milwaukee County Institutions and Departments, Milwaukee.

Delegates to the American Hospital Association are N. E. Hanshus, Robert M. Jones, and Karl H. York, administrator, St. Luke's Hospital, Racine. Their alternates, respectively, are Miss Margaret M. Schloemer, superintendent, Lakeland Hospital, Elkhorn; R. O. Baymiller, administrator, Memorial Hospital, Milwaukee; and M. H. Albrecht.

A PROCLAMATION

WHEREAS, our hospitals are created and operated to serve the public interest; and

WHEREAS, our hospitals are community service institutions that aim to provide the highest possible standard of health care; and

WHEREAS, our hospitals assemble the professionally trained personnel, and the scientific and technical equipment and facilities to care for the ill and the injured; and

WHEREAS, our hospitals keep abreast of the progress made in medical science and translate these advances into services for the individual patient and the community; and

WHEREAS, our hospitals provide individual care to meet the physical, personal, spiritual and emotional needs of each patient; and

WHEREAS, our hospitals depend on community understanding and support to provide the best possible program of health care for the public;

NOW, THEREFORE, I, GAYLORD A. NELSON, Governor of the State of Wisconsin, do hereby proclaim the week of May 6–12, 1962, as

NATIONAL HOSPITAL WEEK

in Wisconsin. Further, I salute all associated with our hospitals for their achievements in the provision of health care, for placing the welfare of each individual patient as the uppermost goal, and for keeping abreast of the advances in medical science and bringing them to our communities. I urge all citizens to join in this observance and to support these vitally needed institutions in their attempts to bring all of us the benefits of medical science and high quality patient care.

(SEAL)

IN TESTIMONY WHEREOF I have hereunto set my hand and caused the Great Seal of the State of Wisconsin to be affixed. Done at the Capitol in the City of Madison this eleventh day of April in the year of our Lord one thousand nine hundred and sixty-two.

[s] GAYLORD NELSON
Governor

POLLUTION COMPLAINT IS FILED PUBLICLY BY SHEBOYGAN DOCTOR

Dr. Richard B. Windsor, Sheboygan physician and surgeon, has made public a formal complaint which he filed with the State Board of Health concerning what he termed the "intolerable sewage situation" affecting the City of Sheboygan from the Erdman area.

The Erdman area is a semi built-up area northwest of the city limits. Because private septic tanks do not work well in the clay soil of the area, residents have connected both their septic tanks and sewers to a drainage pipe provided years ago for drainage of surface water. The 15,000 gallons of polluted solutions which daily drain into the City of Sheboygan and pollute the Pigeon River and Lake Michigan are the cause of Doctor Windsor's complaint. The situation points up the need for a unified city-county public health department, Doctor Windsor said.

DISASTER MEDICAL CARE CONFERENCE

Community Preparedness for Emergencies is the theme of the National Conference on Disaster Medical Care to be held at the Palmer House, Chicago, on June 23.

All interested physicians are invited to attend. Additional information may be obtained from the Department of National Security, American Medical Association, 535 N. Dearborn, Chicago 10, Illinois.

This year's program will consider means of achieving community preparedness, meeting the needs of the public, and new techniques designed to help meet professional needs.

Announce Essay Winners on Handicapped Subjects

Four prize-winning essayists were honored at a recent meeting of the Wisconsin Governor's Committee for the Employment of the Handicapped.

The 1962 Essay Contest in which the State Medical Society is a cooperating sponsor, selected four winners from several hundred essays on "The Role of the Community in the Employment of the Handicapped."

They were Mr. James Florey (first place) Beloit; Miss Patty Jo Uhler (second place) La Crosse; Miss Elaine Stecker (third place) Cedarburg; and Miss Ann Petrie (fourth place) Fond du Lac.

During the course of the ceremony honoring the winners, it was pointed out that Mr. Florey is interested in a career in mathematics or theoretical physics; Miss Stecker in medicine or nursing; Miss Uhler in history and missionary activity; and Miss Petrie in a nursing career.

Talks on Medical Aid

Mrs. Robert Wylde, Madison, chairman of the legislative committee of the Auxiliary to the State Medical Society, spoke to members of the auxiliary to the Kenosha County Medical Society at their April meeting. The Kerr-Mills (medical aid for the aged) Law was her topic.

"CANCER CURE" FEDERALLY BANNED

Interstate shipment of an Asian-grown herb juice, to be mixed with wine for use as a cancer cure and as a stimulant, has been banned by a Federal Court, the Food and Drug Administration has announced. Court action against the product, known as KC 555, was based on charges that it was shipped as a drug without a prior showing of safety, as required by the Federal Food, Drug, and Cosmetic Act. Described as a botanical extract derived from Asian-grown plants to be used as an adjunctive treatment in malignant diseases and as a stimulant when feeling rundown and listless, the product was being distributed across state lines by the Kegan Research Laboratory, Inc., Engle-Wood Cliffs, N. J.

Door County Sets Up New Health Plan

The Door county board of supervisors has approved a new county health system, first of its kind in the state, which is made possible under the Health Commission Law passed at the last session of the Legislature. The law provides that counties can create health commissions which would have jurisdiction over all towns in the county and over all villages and cities in the county which are without a board of health or health officer. Villages and cities, however, which have their own boards of health must act for themselves if they want to abolish their local health authorities and support the county health commission.

The new system in Door county will consist of a health commission-health committee composed of the five present members of the county's health committee, a man who will serve as health director and medical consultant at a salary of $2,000 per year, and two nurses. Sturgeon Bay presently has its own public health program, and it is anticipated that it may take some action to bring the city into the new county health program.

Dr. G. M. Shinners, district health officer, told the board of supervisors that a countywide health program would provide more efficient operation by eliminating much of the duplication of effort that results when there are separate city and county health departments.

POISON CONTROL CENTERS BUSY

A total of 921 cases of poison were reported in 1960 to three of the five poison information centers in Wisconsin, according to a report by the National Clearinghouse for Poison Control.

This included: Milwaukee Children's Hospital, 775 cases; Kenosha Hospital, 98 cases; and Bellin Memorial Hospital, Green Bay, 48 cases. Figures were not included for University Hospitals, Madison, or Luther Hospital, Eau Claire, the other two centers in the state.

Children under 5 made up the majority of the cases, with "baby aspirin" the substance most often taken.

TOURING THE AMA LIBRARY are representatives of Wisconsin county medical societies during the Presidents and Secretaries Conference in March. The library is used to answer mail requests from member physicians and the facilities are available to physicians wishing to visit the AMA headquarters.

TRI-COUNTY GROUP STATES POSITION ON HEALTH CARE OF AGED

The Ashland-Bayfield-Iron Tri-county Medical Association recently expressed its opposition to the King-Anderson Bill and support for Kerr-Mills implementation in Wisconsin.

In a resolution made public and sent to Wisconsin senators and representatives, the association pointed out that the King-Anderson Bill "would institute a system of compulsory health insurance . . . that would lower the quality of health care, with remote and impersonal bureaucratic control replacing the confidence and closeness of the doctor-patient relationship."

The association explained that "the Kerr-Mills Law already is capable of administering a program of medical aid for the aged sensibly designed to help those who need help, coupled with the medical profession's longstanding policy of providing competent medical care regardless of ability to pay."

PRE-MED STUDENTS' DAY

Tours and demonstrations in medical school laboratories and University Hospitals were on the program of a special premedical students' day held at the University of Wisconsin May 5. College students and faculty members throughout the state who are interested in careers in medicine were invited to attend.

MORE CONTROL NEEDED TO STEM RISE IN VENEREAL DISEASES

The State Board of Health has reported growing concern with the control of venereal disease in Wisconsin.

Dr. C. N. Neupert, state health officer, states that U. S. Public Health officials report cases of infectious syphilis have tripled in the United States since 1957, with an especially alarming increase among teenagers.

In Wisconsin there were 1,000 cases of syphilis including 21 deaths, and 1,267 cases of gonorrhea in the state in 1960. Little or no improvement is forecast for 1961 based on preliminary reports. Doctor Neupert estimates that only one out of every four cases of gonorrhea is being reported in Wisconsin.

Wisconsin statutes require reporting by physicians of all cases of venereal disease to the State Board of Health.

Since the most important element in venereal disease control is the tracing of sources and contacts from the diagnosed case, the physician plays a particularly essential role in the control problem.

The State Medical Society's Commission on State Departments is urging the House of Delegates to recommend increased publicity and educational effort among physicians on the problem of venereal disease.

the Wisconsin Medical Journal

June 1962

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NUMBER 6

President's Message to the House of Delegates

By N. A. Hill, M. D.
Madison, Wisconsin

FOR THE past year as your president-elect, I have been about your business, as diligently as possible. It would be futile to tell you how many meetings I attended in the State Medical Society building, as many of you were present at them, and I could not even attempt to give a summary of all of them.

However, I attended two meetings of the A.M.A., one in New York and one in Denver; and from these plus two additional meetings in the Chicago headquarters, I have a much better concept of the scope of work that is being accomplished by the A.M.A.

My observations and study of the problems confronting us today lead me to say "I Don't Want to Set the World on Fire" as your president, I just want to set a few small brush fires here in Wisconsin.

Every day we deal with the multiplicity of insurance forms. For some years, hospital staffs and county societies have held committee meetings to develop forms for the reporting of claims. At the same time, insurance claim departments and underwriters with their medical directors have been working on the same problem, without solving their disagreements. The medical profession does not know the regulations of insurance companies and the laws under which they operate. Insurance company officers are unaware of the problems of our group.

As a major step toward better understanding, I propose that the State Medical Society act as host, and invite the home office management of insurance companies located in Wisconsin, who are engaged in life, health and accident insurance, to a meeting to consider our mutual problems. I understand that the insurance companies already have such a committee. The initial meeting need not be large or expensive. Annual or periodic meetings with medical directors of health plans may well be of mutual benefit in future years.

The recent report of the State Society that at least half of the children in some areas of our State have not been immunized against any disease, not even smallpox, makes me wonder if our educational programs have done any good at all. A few communities have made interesting and original efforts to encourage immunization. Effective and ethical means for using the new vaccines for all of our population is the natural desire of every physician. The interest of the public in the new oral polio

Presented before the House of Delegates at the 121st annual meeting of the State Medical Society, May 7, 1962, Milwaukee.

vaccine should furnish an opportunity to immunize also the large segments of our population who have not been immunized against smallpox, tetanus, diphtheria, and pertussis. Booster doses should be given to those who have let too many years elapse since their original immunizations. The recent smallpox epidemic in England is the result of a lapse in their program. We must not let it happen here. Wisconsin does not require smallpox vaccination for public school admittance, but I wish we could push for a law to compel it. I should like you to consider expanding our immunization programs to take advantage of the advances in this field for the good of all.

As medical care and science progress, a higher percentage of our older population retain both their physical health and their mental faculties into greater ages. Primitive and savage tribes appreciated the wisdom of their older members. But, our own industrial civilization sets the magic number at 65, or at the most 70 for cessation of productive value to society. It is becoming more clearly apparent that these ages are unrealistic. Minds and muscles both must be exercised, or they atrophy from disuse. Our communities and our country cannot afford these losses. Our capable elders deserve the satisfaction and pleasure of being useful citizens, regardless of their calendar years, if little evidence of aging is shown in their cerebrovascular, musculoskeletal and cardiovascular systems.

A medical group, such as this House, needs but to be reminded that each person and his problem are best treated and solved on an individual basis. A monthly check from the government may be the best solution for the few unfortunate who are bedridden. But for the sound and vigorous senior members of our society, income of this sort is the most trivial part of the problem. My idea of medical care of the aged is not in payments under Social Security, but in the security that comes from remaining in their own environment.

Whether it is popular or not, the integrity and self respect of the profession require that ethics and ideals be expounded and defended. Naturally there are honest and intelligent dissenters, and the group of 27 doctors that appeared at the White House recently were of this type. It does seem strange that the opinions of this small group —made up mostly of men who never see a patient in his home, or in a private medical office, or at his work—are given emphasis out of all proportion to their experience in the everyday practice of medicine.

We should continue to strive as a profession to improve the care of the aged, and to oppose expensive and impractical political solutions.

Eight years ago, your State Medical Society joined the State Board of Health in an intensive examination of the organization and facilities of the State Board of Health in New York State and in Virginia. The coroner system in Virginia was also studied. The hospitality and cooperation in both states were remarkable. One purpose of this visit was to obtain information relative to legislation to modernize our own State Board of Health. A portion of the recommended legislation has been passed. Unfortunately, the passage of eight years has made the information obtained obsolete. Our State Board of Health needs help both by legislation and by appropriation of funds—more today than it did eight years ago.

We can be grateful to our scientific journalists, and particularly to the *Milwaukee Journal*, for their careful appraisal of the situation and its presentation to the public.

I recommend to this House of Delegates and to the Council that new studies be made, in cooperation with the legislative and executive branches of our state government, to correct these inadequacies so we may again be proud of our progressive spirit and actions in the area of public health.

Finally, joint meetings with the legal and journalistic professions in recent years have been of great value to all. Mutual interests, problems and goals are better known, and means of improving relations better understood. I recommend that the contacts with these professions be continued, and that we extend them to include all allied professions that share our backgrounds, such as the dental, nursing, veterinary, and pharmacy professions. We could share our knowledge, discuss our problems, to the benefit of all.

So, let us work together to accomplish some of these aims. I shall try to be as effective and as forceful a president as I can, but if I should be unable to do all I set out to do, I can be like the poodle at the dog show who said: "I may not win any prizes, but I'll meet some awfully nice dogs."

Pulmonary Embolectomy
A Simplified Technique

By R. D. SAUTTER, M. D., B. R. LAWTON, M. D.,
G. E. MAGNIN, M. D., and J. L. BURNS, M. D.

Marshfield, Wisconsin

A RECENT report of a pulmonary embolectomy technique, employing cardiopulmonary bypass, by Cooley et al.,[1] prompted us to describe another method. The technique is swift, simple, requires no elaborate equipment, and could be performed by any competent surgeon. It provides better control of hemorrhage than the original operation of Trendelenburg[2] and more efficacious control than the Wieberdink[3] modification. We believe it is as effective as Cooley's technique. It provides an additional interval during which hypothermia or cardiopulmonary bypass can be instituted.

The following case report illustrates the general principles of the technique.

CASE REPORT

On July 1, 1961, a 39-year-old woman was in an automobile accident. She sustained fractures of the eighth and ninth ribs on the left side and second rib on the right side. She also had fractures of the fibula and medial malleolus on the right side and a comminuted fracture of the calcaneus on the left side. Bilateral lower leg casts were applied at a hospital near the accident.

On July 6, 1961, she complained of sharp stabbing pain in the left lower quadrant and was transferred to another hospital. Her hemoglobin level on admission was 6 gm. per 100 ml. An exploratory laparotomy confirmed the preoperative diagnosis of ruptured spleen. A large hematoma was evacuated and splenectomy was performed. At the end of the procedure, her condition began to deteriorate. Over transfusion was suspected, and she responded to phlebotomy and tracheostomy. Shortly after the operation, she was given digitalis because of acute pulmonary edema. Fig. 1 shows the electrocardiographic results at that time. Her general condition showed progressive improvement. The leg casts became loose and on July 20, 1961, new casts were applied.

At 11:30 a.m. on July 21, 1961, she became very dyspneic and perspired profusely. Her pulse rate was 140 per minute and blood pressure was 55/0 mm. Hg. Electrocardiographic studies (Fig. 2) showed acute strain of the right side of the heart and the diagnosis of acute pulmonary embolus was made. A vasopressor, norepinephrine, and oxygen were administered, and her condition improved. Arrangements were being made for surgery using hypothermia. At 3 p.m. her conditon further deteriorated so she was moved to the operating room. As she was being transferred to the operating table and wrapped in the cooling blanket, cardiac arrest occurred.

The chest was immediately opened per bilateral "trap door" thoracotomy at the sixth interspace with cardiac massage instituted and maintained. A tube was placed in the trachea and she was ventilated with oxygen. The pericardium was opened transversely from phrenic nerve to phrenic nerve and superiorly along the great vessels. The right atrium, right ventricle, and pulmonary artery were tense and distended. The ventricle was contracting poorly. Umbilical tape slings were placed around the inferior and superior vena cavae and passed through lengths of rubber tubing. A curved Pott's atraumatic clamp was applied. A longitudinal incision was made in the pulmonary artery, previous to which traction sutures of 00000 arterial silk had been placed superiorly, inferiorly, and bilaterally. The patient was still normothermic at this point. The slings were tightened, occluding the cavae. After the heart emptied, the atraumatic clamp was released and a sucker was introduced into the pulmonary artery. Small fragments of thrombus were obtained. The clamp was reapplied to

From the Marshfield Clinic.

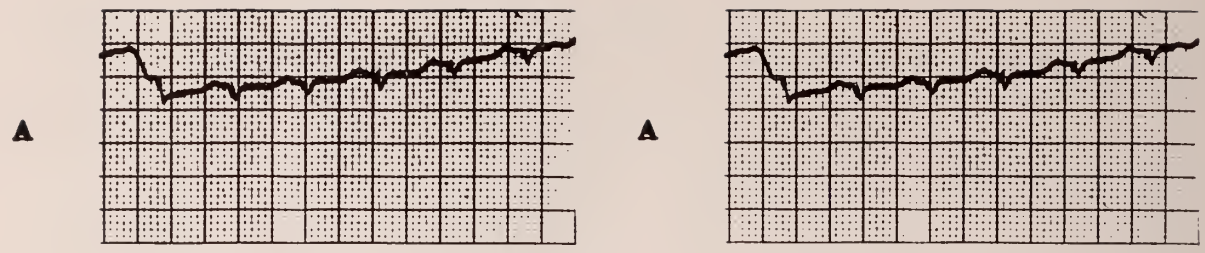

Figure 1

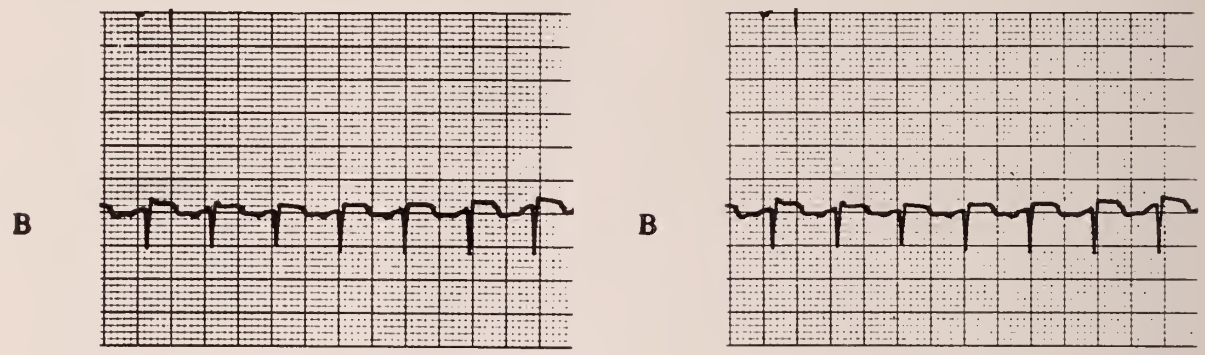

Figure 2

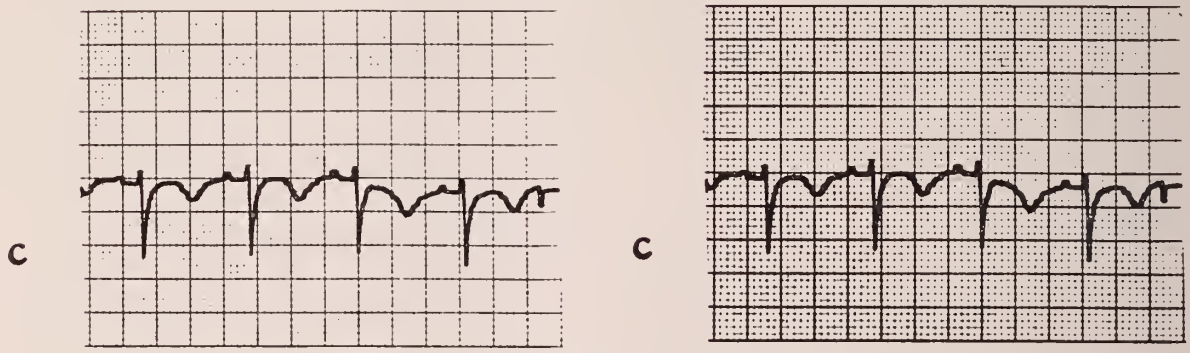

Figure 3

the pulmonary artery and the slings released after 45 seconds. The right atrium was still distended, but better right ventricular contraction was apparent.

While the patient was allowed to recover during the next 15 minutes, the inferior vena cava was ligated just proximal to its bifurcation via the extraperitoneal approach. During a second period of occlusion, lasting 75 seconds, larger pieces of emboli were recovered from the left pulmonary artery. After release of the slings, the atrium was less tense and the ventricle more vigorous. After a recovery period of 10 minutes, a 90-second period of occlusion allowed removal of additional larger fragments of emboli from the right pulmonary artery. Although the atrium was still distended, it was much softer than it had been and the ventricle was quite vigorous. Norepinephrine therapy, started prior to surgery, was discontinued; the systolic blood pressure remained at 100 mm. Hg. The pulmonary artery was closed with a whip stitch of 00000 arterial silk, and the abdominal and thoracic wounds were closed with bilateral underwater seal drainage of the chest. A tracheostomy tube was reinserted. At the end of surgery, her body temperature was 95 F. (35 C.).

Because of the suspected threat of cerebral edema, the patient was maintained at 87.8 F. (31 C.) body temperature for the first 16 hours postoperatively. During this time she excreted urine in adequate amounts. She responded to verbal stimuli during this period; and during the last 2 hours of hypothermia as her temperature rose, she became aware of her surroundings and then verbalized.

After normal body temperature was reached, she was alert and conversational. She remained in this state until shortly before her death. Her systolic blood pressure rose from 100 to 120 mm. Hg. An electrocardiogram (Fig. 3) obtained postoperatively showed marked improvement. During her last 30 hours, respirations slowly but progressively became more labored, and 12 hours prior to her death she was placed on the Bennett positive pressure demand breathing apparatus. Her blood pressure and urinary output remained unchanged until approximately 5 hours prior to her death. During the last 5 hours the systolic blood pressure fell slowly and 3 hours prior to death, norepinephrine was added to the infusion. However, this would not support her and she died July 30, 1961, 52 hours after surgery.

Autopsy studies revealed the chief cause of death to be multiple bilateral pulmonary emboli. There were multiple emboli present in the inferior vena cava and common iliac vein, distal to the point of ligation. There was minimal cerebral swelling which was not considered as the cause of death. The remainder of the findings were secondary to the surgical procedures.

COMMENTS

As shown by the autopsy, pulmonary emboli were the chief cause of death. However, since there was marked improvement in her condition immediately following surgery, propagation of the retained emboli is a possibility as the cause of the gradual deterioration. Had we suspected that large emboli remained in the pulmonary artery and persisted in our effort for their removal, we feel this could have been accomplished at even normothermic levels with periods of 2 minutes or less of occlusion. The procedure would have been greatly facilitated by hypothermia of sufficient degree to allow 6 to 8 minutes of occlusion. This can be established, if sufficient time is available, with icebags placed on the groin, abdomen, neck, and axillae. As this case demonstrates, the patient can be afforded temporary relief by periods of normothermic occlusion with removal of as many emboli as possible until hypothermia can be established. If special equipment is available, hypothermia of a degree (78.8 F., or 26 C.) to allow 15 minutes of occlusion could be established, if such is necessary. This, we believe, would be simpler, more expeditious, and equally as effective as cardiopulmonary bypass. It is important to note that this patient, even in extremis, tolerated three periods of less than 2 minutes of occlusion without serious sequelae. The cerebral edema at autopsy was minimal and related to her terminal asphyxia.

The incision employed deserves special consideration. It can be made in the sixth or seventh interspace, across the intercostal musculature and through the costal cartilage and xiphoid. While the exposure is not ideal, it is certainly adequate and has many advantages. Since transection of the sternum is not necessary, it is swift; and when made under nonsterile conditions, it eliminates the possibility of osteomyelitis. Also, since it is below the internal mammary vessels, control of bleeding, which is often troublesome, is not a problem. The incision is not particularly difficult to close; it is easier than the usual transsternal bilateral thoracotomy.

Our treatment of choice for the patient who appears to be dying of massive pulmonary embolism is as follows:

1. Immediate bilateral thoracotomy and cardiac massage.
2. Mouth-to-mouth breathing until endotracheal ventilation with oxygen is available.
3. Intravenous vasopressor, preferably norepinephrine, 4 ml. in a solution of 500 ml. of 5% dextrose and water.
4. Rapid digitalization.
5. Transfer to operating room while maintaining cardiac massage.
6. Initiation of hypothermia by whatever means is available.
7. Repeated embolectomies with less than 2 minutes of caval occlusion until sufficient improvement in cardiac action is obtained.
8. Transabdominal extraperitoneal ligation of inferior vena cava.
9. Embolectomy under hypothermia with longer periods of occlusion as body temperature falls until all possible emboli are removed.

Our treatment of choice for patients less seriously ill is:

1. Intravenous vasopressor and rapid digitalization.
2. Transfer to operating room and commencement of hypothermia.

3. Sterile preparation of abdomen and chest.
4. Extraperitoneal transabdominal ligation of inferior vena cava.
5. Bilateral thoracotomy and pulmonary embolectomy when sufficient hypothermia is obtained to allow 6 to 8 minutes of occlusion. Repeat if necessary. Earlier embolectomy at normothermia, if the patient's condition deteriorates.

SUMMARY

An additional technique for pulmonary embolectomy is described which should allow more surgeons with only modest facilities to treat this disease. Although unsuccessful in its first trial, this technique was sufficiently appealing to warrant further trial and consideration by others.

630 South Central Avenue.

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one of a series

ROENTGEN RIDDLE . . .

HISTORY: A 63-year-old Italian-born man entered the hospital with cough, shortness of breath and ankle edema. A chest x-ray substantiated the clinical diagnosis of congestive heart failure, but the radiologist suggested obtaining roentgenograms of the soft tissues of the thigh. No past history of convulsions.

PHYSICAL EXAMINATION: Besides findings supporting congestive heart failure, eosinophilia was noted.

X-RAY: Evident in the soft tissues of the thigh were eliptical nonhomogeneous calcified densities. These measured up to 1.0 cm. in length and their longitudinal axes were situated roughly in the planes of the striated muscle bundles. Similar lesions were seen in the muscles of the upper arms and shoulder girdle.

Prepared by A. M. Richter, M. D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M. D., radiologist, Department of Radiology at Milwaukee County Hospital.

DISCUSSION on page 320

Fig. 1—Anteroposterior radiograph of the thigh.

Choledochal Cyst; Report of a Case in a Five-Year-Old Child

By WILLIAM MERKOW, M.D.

Waukesha, Wisconsin

TRUE CHOLEDOCHAL cyst or congenital cystic dilatation of the common bile duct, a rare cause of abdominal pain in patients of all ages, is more frequent in children. This condition is to be distinguished from general dilatation of the biliary system secondary to obstruction of the extrahepatic ductal system from stones, stricture or neoplasm. Judd and Greene[1] report 1 case in 17-381 biliary tract operations at the Mayo Clinic and Smith[2] reports 2 cases in 757,000 hospital admissions at the Presbyterian Hospital, New York. There have been approximately 200 cases reported in the world literature.

CASE REPORT

A 5-year-old white girl, complaining of intermittent abdominal pain, was admitted to the hospital on July 18, 1961. She had been hospitalized on three previous occasions for similar distress. A summary of the records of these admissions is as follows:

She was admitted July 30, 1958, with a four-month history of intermittent colicky periumbilical pain. An umbilical hernia was the only abnormal physical finding. Umbilical herniorrhaphy, appendectomy, and release of an omento-umbilical band were carried out. The gallbladder was considered negative. She made an uneventful recovery and was dismissed on August 12, 1958.

The second admission was on August 16, 1959, again because of abdominal pain. Some improvement was noted with the use of antispasmodic drugs. All x-ray studies, including chest, upper and lower gastrointestinal tract and intravenous urography, were normal. She was discharged on August 20, 1959, with a diagnosis of abdominal pain, etiology undetermined.

The third admission was on June 25, 1961, again because of intermittent colicky abdominal pain but now associated with vomiting. Abnormal physical findings were conspicuous by their absence. Extensive laboratory studies were all normal except for mild anemia and albuminuria. Complete x-ray studies were repeated. There was evidence of pressure on the distal gastric antrum and descending duodenum. Two successive series of oral cholecystography were carried out; the first resulted in nonvisualization. The second visualized normally, but the gallbladder appeared larger than would be considered normal for a patient of this age. The colon x-ray film and intravenous urography were reported as normal. The episodes of pain subsided on antispasmodic medication and she was dismissed from the hospital on July 3, 1961.

Final admission to the hospital was on July 18, 1961, because of recurrent crampy abdominal pain and vomiting unrelieved by medication. Bouts of pain were experienced daily one week prior to this admission. There was no change in bowel habit and no jaundice, past or present.

She had mild to moderate right upper quadrant tenderness. The abdomen was soft throughout and no palpable masses of significance were present. X-ray films showed the chest was normal. On x-ray examination of the upper gastrointestinal tract the esophagus and stomach were normal. There was a persistent deformity along the posterolateral aspect of the duodenal bulb. This extended from the mid bulb across the apex and down to the proximal portion of the descending limb of the duodenum. The major deformity, however, was in the region of the duodenal bulb apex. The radiologist's primary considerations in the differential diagnosis were: (a) choledochal cyst, (b) enteric cyst (reduplication of the intestine at this site), (c) aberrant pancreas or partial annular pancreas. Subsequent cholecystocholangiography using 7 ml. of iodipamide methylglucamine (Cholografin) demonstrated an extrinsic pressure deformity on the superior aspect of

From Waukesha Memorial Hospital.

the duodenal cap secondary to dilatation of the proximal common bile duct. The second portion of the duodenum was narrowed where the common bile duct passed posteriorly. The radiological impression was choledochal cyst.

She had mild anemia and her urine contained a trace of albumin and a trace of bile. Her serum amylase and alkaline phosphatase were slightly elevated. The serum bilirubin, fasting blood sugar and thymol turbidity tests were normal. The stool contained red blood cells. Ova and parasites were not seen.

On July 25, 1961, she underwent surgery. The gallbladder was enlarged. A cystic mass was encountered in the region of the common bile duct which filled the entire subhepatic area covering the common and hepatic ducts. Because of increased vascularity between the stomach, duodenum and cyst, dissection was kept at a minimum. The cyst was attached to the superior border of the duodenum, the location of the planned anastomosis. It pressed firmly against the head of the pancreas which projected into the first portion of the duodenum. Its volume was about 100 ml.; 40 ml. of dark bile were removed. A two-layer choledochocystoduodenostomy was carried out without difficulty. The anastomosis was 1.25 cm. long. It was noted at the conclusion of the procedure that the size of the gallbladder had decreased considerably.

Her only postoperative problem was an acute febrile reaction of a 105 F. temperature on the fifth postoperative day which was thought to be due to retention of bronchial secretions and laryngitis. The abdomen was soft and flat throughout her postoperative course. Her temperature returned to normal in 24 hours. She was dismissed from the hospital on August 4, 1961, her tenth postoperative day, and has been well since. Intravenous cholecystocholangiography was repeated on October 14, 1961, and demonstrated prompt emptying of the hepatic radicals and no evidence of the previously described choledochal cyst.

COMMENT

Choledochal cyst is probably a congenital lesion; the exact mechanism of production is unknown. Many factors are important, such as stenosis of the distal portion of the common duct, angulation or valve-like fold of the distal portion of the common duct, failure of the sphincter of Oddi to relax at the proper time, lack of contractile elements and weakness of the wall of the common duct, congenital valve formation secondary to malformation of the duct. Congenital weakness of the common duct wall is the most likely cause.[4] The cyst may involve only the common duct or may include the junctions of the cystic and hepatic ducts. The pancreatic duct may also open into the cyst. True choledochal cyst is usually localized whereas purely obstructive lesions tend to cause dilatation of the entire biliary system. Smith[2] considers the most logical explanation of pathologic embryology that offered by Yotuyanagi, namely an unequal proliferation of epithelial cells at the stage of development when the common duct is a solid cord. The cyst wall is fibrous and usually without epithelial lining. Cysts vary in size and may contain calculi.[3] The cysts gradually enlarge and because of their weight tend to hang to one side causing further angulation, obstruction and pressure on adjacent organs.

The typical clinical syndrome is described as a triad of abdominal pain, palpable mass, and jaundice. Our patient had only intermittent colicky upper abdominal pain with occasional vomiting. Pain may be colicky, dull or dragging but is usually located in the epigastrium or right upper quadrant. Jaundice has been reported in 90 per cent of patients. Jaundice was absent in our patient, but the alkaline phosphatase was slightly elevated and a trace of bile appeared in the urine during the last hospitalization. Low-grade fever may be present and usually is indicative of infection. The chronicity and intermittency of complaints are noteworthy. The condition is four times more common in females than in males. The age varies from birth to over 40 years. It is most common under the age of 10.

The surgical procedure of choice is to create a communication between the cyst and the upper gastrointestinal tract. Many surgical techniques have been used, including external drainage, excision of the cyst and cholecystenterostomy. However, best results are obtained by cystoduodenostomy with or without catheter decompression of the cyst or gallbladder. Mortality for procedures other than those designed to establish biliary intestinal continuity is prohibitive. The Roux en Y principle of biliary intestinal diversion has also been recommended. Our patient was treated by direct choledochocystoduodenos-

tomy without catheter decompression. No complications were encountered. The advocates of cystojejunostomy utilizing the Roux en Y principle connecting the cyst to an antiperistaltic loop of jejunum claim that this maneuver lessens the chance of ascending cholangitis. This procedure is useful; however, it is more time consuming and involves additional intestinal handling.

SUMMARY

A case of choledochal cyst in a 5-year-old girl is presented. A preoperative radiological diagnosis was made and successful surgical treatment carried out. The diagnosis of choledochal cyst can be made preoperatively by awareness, upper gastrointestinal contrast studies and intravenous cholecystocholangiography.

Surgical management should be directed towards establishing continuity of the cyst to the upper gastrointestinal tract either by direct choledochocystoduodenostomy or cystojejunostomy by Roux en Y principle. We used direct choledochocystoduodenostomy successfully in our patient. The procedure is simple and can be quickly accomplished. The danger of ascending cholangitis is minimal providing proper attention is given to the caliber of the anastomosis.

324 West Main Street.

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LABORATORY NOTES No. 1 of a series

Congenital Hemolytic Anemia (Spherocytic Anemia)

EDITOR'S NOTE: A series of articles briefly presenting information pertinent to disease processes from the standpoint of laboratory data begins in the WISCONSIN MEDICAL JOURNAL *with this issue. The articles have been prepared by S. H. Holt, M. D., Director of Laboratories, Kenosha Hospital, Kenosha, Wisconsin. Acknowledgment of the sources of information for the entire series is given in the footnote.*

This type of anemia is caused by an intrinsic defect in the erythrocytes which results in excessive destruction of the cells by the spleen. The disease is hereditary, nonsex-linked and is Mendelian dominant. The disease is found in all races except Negroes and is especially prevalent in persons of European descent.

Erythrocytes of these patients have a decreased osmotic fragility in vitro and are rapidly destroyed in vivo. The defect lies in the erythrocytes and not in the plasma or spleen as erythrocytes from a normal person have a normal survival time after transfusion into a patient with congenital hemolytic anemia.

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Laboratory Findings

1. Hemoglobin level is reduced.
2. Hematocrit reading is reduced.
3. Spherocytes are present on peripheral blood smears.
4. Fragility test of erythrocytes shows increased fragility of the cells.
5. Reticulocytes are increased.
6. Serum bilirubin is increased.
7. Indirect van den Bergh test is increased.
8. Blood cholesterol is usually reduced.
9. Urine urobilinogen is increased.
10. Urine urobilin is increased.
11. The Coombs test is negative.
12. Serum methemoglobin is increased.
13. Fecal urobilinogen is increased.
14. Serum iron is increased.
15. Serum iron-binding capacity is decreased.

Removal of the spleen will prevent destruction of the abnormal cells and will correct the anemia. However, the abnormal cells, the spherocytes, will remain in large numbers for the duration of the patient's life.

Anticoagulants—the Cases For and Against

A Summary of a series of articles presented in the Journal of the Oklahoma State Medical Association, February, 1962

The entire February 1962 issue of *The Journal of the Oklahoma State Medical Association* was devoted to "Anticoagulants—the Cases For and Against." Several cardiologists were asked to review impassively what is known about the value of anticoagulant agents in four clinical situations.

The first discussant stated the case for anticoagulants following acute myocardial infarction. In over 1,000 patients the mortality rate was 23 per cent in the control group compared with 16 per cent in the anticoagulant group. The incidence of embolic complication was 26 per cent of the control group compared to 11 per cent of the anticoagulated group. Pulmonary emboli were found in 23 per cent of the control patients and 8 per cent in the treated patients. In the same study it was found that there was no difference between the two groups regarding incidence of new infarctions or extension of coronary thrombosis, suggesting little change in the coronary circulation. The dangers of hemorrhagic complications from anticoagulant therapy are ever present. The danger of sudden termination of anticoagulant therapy was noted because withdrawal results in a greater tendency for the patients to have thrombosis.

In the case against using anticoagulants following acute myocardial infarction, the author summarized by stating that in treating acute infarction patients it would seem advisable to give them as much personal attention as if they were being treated with anticoagulants and such psychotherapy as is indicated; to use vasodilators, sedation, oxygen, and bed rest liberally; and to reserve the anticoagulants for a more prudent use—that of a rat poison.

The long-term oral anticoagulant therapy in myocardial infarction results in a decrease in the mortality of five or six times, a decrease in the significant complications of two to three times, and no significant danger of hemorrhage to the patient. The author presenting the opposite point of view summarized by saying that the hypothesis that continuous long-term anticoagulant therapy is effective in preventing recurrences of myocardial infarction is a hypothesis and is not yet established fact. The most that might be expected is that the number of recurrences may be lessened for the first few months after infarct but even these data are inconclusive. Not more but better studies are needed to draw valid conclusions as to the worthwhileness of the proposed therapy.

The long-term anticoagulant therapy in arteriosclerotic cardiovascular disease manifest by angina pectoris is recommended for selected patients. The exact degree of its effectiveness in reducing mortality in the probability of future myocardial infarctions remains unanswered. Data supporting the value of long-term "anticoagulation" is reviewed. It appears that the death rate can be reduced by about 30 per cent annually. Further improvement in the prognosis for arteriosclerotic cardiovascular disease with angina pectoris awaits prevention of myocardial infarction in the absence of coronary thrombosis and development of techniques for recognition and treatment of patients prone to ventricular fibrillation. The opposite point of view is stated in the conclusion that "attention is again called to the impropriety of making a case for or against anything without good evidence." An attempt has been made to examine the evidence and this has been found to be difficult, and not clear cut. At the present time it seems wise to treat patients for a year or so with anticoagulants when angina pectoris has existed two years or less, and to withhold such treatment if the syndrome has existed two years or more. By no means has this matter been settled, and as more evidence is accumulated, one should be ready to revise one's attitude.

The use of anticoagulants in impending myocardial infarction was discussed since the syndrome appears to be a distinct entity, and its recognition is increased in frequency with the advent of anticoagulant medications. Reported results obtained through the use of anticoagulants during the interval of impending myocardial infarction are impressively good. There does appear to be a need for more controlled studies. However, it is not unusual to see a patient whose attacks continue unabated in spite of adequate amounts of heparin, with his course climaxed by acute myocardial infarction, or ended by sudden demise. Until otherwise demonstrated, it appears advisable to employ adequate amounts of heparin in the treatment of impending myocardial infarction, and follow this acute phase with long-term maintenance anticoagulant therapy.

The opposing author states that acute coronary insufficiency is difficult to define. No satisfactory large series exists for mortality studies with and without long-term anticoagulant therapy. However, the prognosis in acute coronary insufficiency may be better than one would anticipate. There is a risk of fatal bleeding complication along with anticoagulant treatment approximating one per cent with even more of the less severe bleeding episodes. —V. S. Falk, Jr., M.D., Edgerton

Nonparasitic Cyst of the Liver With Obstructive Jaundice

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SOLITARY nonparasitic cysts of the liver are rare. Geist[1] collected 193 cases from the world literature up to 1954. Since then additional articles have appeared, making the total over 200 cases. Hanson, Gray and Docherty[2] reported 38 instances of simple unilocular cysts of the liver at the Mayo Clinic from 1907 to 1954, inclusive. Of these, 12 had symptoms relating to the cyst. In the remaining 26, the lesions were found incidentally at operation for some other condition.

Symptoms vary widely. There may be pain, awareness of an abdominal mass, nausea, vomiting and various forms of indigestion. Pain may be of two types: a dull ache, aggravated by motion or change of position, or, intermittent episodes of severe pain, sometimes accompanied by chills and fever, with residual soreness for several days. Narcotics are occasionally needed for relief of pain. The latter type is thought to be due to hemorrhage into or rupture of the cyst.

Findings also vary. A mass may be felt. Laboratory examinations are usually within normal limits. X-ray films may show displacement of adjacent organs.

Diagnosis usually is not made until the time of surgery. Most of the cysts protrude in whole or in part from the liver surface.

Therapy includes aspiration, drainage, marsupialization, resection in part with suture obliteration of the cavity and anastamosis to the intestinal tract. Anderson and Shields[3] reported a case treated by aspiration and insertion of a Foley catheter.

The following case is reported for two reasons: (1) the cysts of the liver were wholly intrahepatic, and (2) the association with them of complete obstructive jaundice.

From St. Mary's Ringling Hospital, Baraboo, Wisconsin.

CASE REPORT

A 74-year-old white woman presented herself for physical examination April 25, 1960. She stated she had been ill for two weeks with upper abdominal pains, nausea, vomiting and constipation. Her past history included two episodes of what were thought to be gallbladder attacks in 1941 and 1949. X-ray films taken in 1941 showed a normally functioning gallbladder with no evidence of stones. She was hypertensive. Examination disclosed a deeply icteric woman with abdominal distention and tenderness and rigidity in the right upper quadrant. Her temperature was 99 F., pulse 94 and blood pressure 210/90.

The patient entered a hospital and because of her age was treated conservatively for 16 days. Exploratory laparotomy was performed on May 12, 1960. The liver was enlarged and tense. The gallbladder was soft and without stones. The common duct was normal in size. The pancreas was normal. A small cyst was present on the anterior inferior border of the right lobe of the liver. This was excised for biopsy. While a suture was being placed to control the liver bleeding, there was a gush of muddy fluid and the liver decreased markedly in size. The true nature of the condition was not determined at that time. A cholecystotomy was done for future diagnostic purposes, the abdomen was closed, and a rubber dam drain was brought through the skin incision. Pathologic diagnosis was simple cyst of the liver.

After the operation a subphrenic abcess developed and was drained. The patient left the hospital July 2, 1960.

She remained in good health until December, 1960, when she again developed pain, weakness and jaundice. Surgery was performed Dec. 20, 1960. A right subcostal incision was carried down to the peritoneum.

Without opening the peritoneum, a trocar was introduced into the right lobe of the liver and 1,500 cc. of muddy fluid were recovered. A catheter was inserted through the trocar and the trocar was withdrawn. The wound was closed and the catheter was anchored to the abdominal wall. The patient went into deep shock and was treated with blood transfusions, *l*-norepinephrine (Levophed) intravenously and steroids. She was maintained on steroid therapy, and the icteric index and liver function tests returned to normal. However, she never regained her strength. On the forty-ninth day after the operation she suddenly went into extreme shock and died within 24 hours in spite of the increased dosage of steroids and *l*-norepinephrine.

At autopsy external findings revealed a recent healing oblique surgical incision beneath the right costal margin with a 1 cm. fistula opening just below it. The fistula passed through dense fibrous adhesions in the right upper quadrant and communicated with a large intrahepatic cyst 8 cm. in greatest diameter. The cyst was in the depths of the liver and its inferior aspects compressed and distorted the intrahepatic vessels and ducts at the hilum. The cyst was completely surrounded by hepatic tissue. It was filled with thick brown chalky fluid not under pressure. The lining was made up of soft, ragged hemorrhagic material with a peripheral dense fibrous membrane 1 to 3 cm. in thickness. The cystic cavity was closed except for the sinus opening. It was separated by a thin fibrous membrane from a smaller but otherwise similar cyst 3 cm. in greatest diameter just above it.

Lying over the entire left lobe of the liver and extending far over the superior surface of the right lobe was a ragged surfaced, thick-walled, collapsed cavity lined with necrotic granular material. The upper part of the structure was made of a dense fibrous membrane intimately attached to the diaphragmatic wall, and the lower part consisted of thickened liver capsule. Its lumen appeared to be completely enclosed and there was no visible external communication.

The remainder of the liver tissue was firm. The lobular pattern was somewhat accentuated but there were no other focal lesions.

The gallbladder was embedded in fibrous adhesions involving most of the normal structures of the right upper quadrant area. The wall of the gallbladder was irregularly thickened. The lumen contained dark bile and no stones. The distal hepatic duct and the common duct were slightly dilated, patent and contained no bile. There were no cysts of the kidneys, pancreas or lungs.

Microscopic examination of the main cyst wall showed a lining made up of granulation tissue heavily infiltrated with lymphocytes and plasma cells. Large histiocytes filled with granular bile pigment were scattered throughout. This granulation tissue contained small islands of degenerated liver tissue. Deeper in the wall the connective tissue was more heavily collagenized and had small collections of inflammatory cells. No microbiological organisms were found. In contrast to the surgically excised cyst, which was lined by a noninflammatory columnar epithelium, no epithelium was found in any part of the cysts examined at autopsy.

The subdiaphragmatic cavity was lined by dense fibrous tissue and accumulations of chronic inflammatory cells.

The final diagnoses were:

(1) Non-neoplastic cyst of the liver; residual chronic inflammatory reaction, and fibrosis and external surface drainage.
(2) Subdiaphragmatic abscess, post drainage; residual chronic inflammatory reaction and fibrosis.
(3) Abdominal adhesions, right upper quadrant area.

Death was attributed to arteriosclerotic heart disease and cardiac failure aggravated by obstructive jaundice and chronic hepatic disease.

SUMMARY

A case of nonparasitic cyst of the liver with obstructive jaundice is reported, with the cyst wholly within the liver substance and associated with complete obstructive jaundice. The literature is reviewed and therapy discussed.

(J.H.H.) P.O. Box 325.

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State Board of Health Recommendations for the Use of Poliomyelitis Vaccine

THE WISCONSIN State Board of Health at the May 18, 1962, meeting adopted as its policy on the use of poliomyelitis vaccine in Wisconsin the recommendations submitted by the Poliomyelitis Advisory Committee.

This committee included the following persons: Ruth Church, M. D., Waukesha County Health Department; Leon Gilman, D. O., Wisconsin Association of Osteopathic Physicians and Surgeons; N. A. Hill, M. D., State Medical Society of Wisconsin; Charles K. Kincaid, M. D., Madison Health Department; Edward R. Krumbiegel, M. D., Milwaukee Health Department; William E. Meisekothen, M. D., Wisconsin Academy of General Practice; J. R. Schroder, M. D., Wisconsin Academy of Pediatrics; Horace K. Tenney, III, M. D., University of Wisconsin Medical School; G. G. Shields, M. D., District Health Officer, Wisconsin Rapids; Josef Preizler, M. D. and James L. Wardlaw, Jr., M. D., State Board of Health.

I. Both the oral (Sabin) and the formaldehyde-inactivated (Salk) poliomyelitis vaccines have greatly decreased the rates of clinical poliomyelitis among persons receiving them.

The killed vaccine has been used since 1955. It can be combined with diphtheria, tetanus and pertussis antigens as part of routine pediatric or well-baby clinic practice. It can be administered by injection only. It contains all three types of poliomyelitis antigens and a single injection calls forth a prompt antibody response to all three types.

The ease of administration of oral vaccine simplifies mass immunization and makes it of special value for organized community-wide immunization programs designed to raise the general immunity to the highest possible levels, to reach those segments of the population that have failed to be vaccinated, and to stop epidemics.

Further advantages for the use of the oral vaccine during epidemics are the promptness of the antibody response to the specific type administered, and the fact that alimentary tract infection with the vaccine strain temporarily interferes with the possible spread of wild polioviruses.

Each strain must be administered as a separate dose and effective antibody titers are demonstrated for a longer period of time than for the killed vaccine.

The presence of other enteroviruses in the intestinal tract interferes with the development of immunity and restricts the use of this vaccine for primary immunization to the late fall, winter and spring months.

II. Vaccination Program for Nonepidemic Use

Oral (Sabin) vaccine should not be used in Wisconsin this year until mid-October except in areas where an epidemic is impending. Physicians and public health agencies should continue to immunize individuals with the Salk vaccine as they have in the past, at least until October 15. The reasons for this recommendation are:

1. There is no imminent danger of a poliomyelitis epidemic in those segments of the population which are well protected with the Salk vaccine.
2. During the months from May to October other enteroviruses are prevalent in the intestinal tract in a large number of persons. Since these viruses interfere with the "take" of the oral vaccine, a great number of persons may not obtain protection from the oral vaccine used during this season.
3. The presence of attenuated strains in the stools of vaccinated persons will complicate the diagnosis of clinical cases of poliomyelitis since the present laboratory services in Wisconsin are unable to differentiate between the attenuated and wild strains.

III. Mass Immunization for Impending Epidemic

At the time of an impending outbreak, rapid mass vaccination of the susceptible population should be carried out among preschool children, school-age children and as many persons as possible under 50 years of age using live (oral) vaccine of the type identified in the outbreak. An assessment of the possibility of an impending epidemic will be made by the State Board of Health in consultation with the local health authorities. Each community should draw up a plan for mass immunization with oral vaccines to control an epidemic.

Communities that have used live vaccine against one type of paralytic poliomyelitis because of an impending epidemic should follow through and vaccinate the same persons against the other two types as promptly as possible at appropriate intervals to protect against all three types of paralytic poliomyelitis.

IV. Oral (Sabin) Vaccine in Private Practice and Routine Immunization Clinics

The Committee recommends that in the use of oral vaccine in private practice and in clinics after October 15, the physician be urged to give such immunization on a *family basis* without regard to previous polio immunization. Nonparticipation of a family member should not be an indication to withhold the immunization from the other members of the family.

The plans should assure the ready availability of the vaccine in all areas of the community and for all persons within the selected target groups. Special emphasis must be directed to those areas and population groups having the lowest levels of immunization, and community-wide programs should

achieve the immunization of the maximum number of persons.

If the susceptible population in Wisconsin receives adequate immunization with the oral (Sabin) vaccine during the fall, winter and spring, there will be no objection to the use of oral (Sabin) vaccine during all seasons beginning in 1963.

V. Dosage Schedule for Nonepidemic Use

a. *Oral (Sabin) Vaccine (Monovalent)*

It is recommended that the three types of oral vaccines be administered sequentially, each in monovalent form at intervals of about six weeks. Special efforts will be necessary to maintain a high level of community interest and public response to obtain the necessary coverage.

(1) INFANTS: Immunization should be initiated between six weeks and three months of age and subsequent doses given according to the following schedule:

Number of Doses	*Type*	*Interval from Previous Dose*
First	I	--------
Second	III	6 weeks
Third	II	6 weeks
Fourth	I, II, and III	6 months or longer

Note: Not all infants develop good response to the administration of monovalent vaccine. Therefore the fourth dose is recommended containing all three strains to give immunity to those infants who may not respond as fully to the previous administration of the single vaccines.

(2) ALL OTHERS (Including community use):

Number of Doses	*Type*	*Interval from Previous Dose*
First	I	--------
Second	III	6 weeks
Third	II	6 weeks

b. *Formaldehyde-Inactivated (Salk) Vaccine*

Immunization should be initiated in infants between six weeks and three months of age according to the following schedule:

Number of Doses	*Interval from Previous Dose*
First	----------
Second	6 weeks
Third	6 weeks
Fourth	6 months or longer

The same schedule may be used for other age groups in the interest of achieving higher levels of immunity before the 1962 poliomyelitis season.

The Advisory Committee believes that persons who received four injections of Salk vaccine, two of which were given since 1959 and the last one within a year, are adequately protected against the paralytic form of poliomyelitis. Vaccines produced before 1959 were not of optimum potency and the rapid fall-off of the neutralizing antibodies following the use of the inactivated vaccine makes it advisable to have a recall injection within a year of the beginning of the poliomyelitis season. The use of the oral vaccine may make the yearly recall injections unnecessary. However, future research will give definite answers to this problem.

VI. Surveillance

a. All physicians are urged to send proper stool specimens to the State Laboratory of Hygiene from all suspect cases of poliomyelitis for virus studies. This laboratory is urged to send the reports to the practicing physicians and to the State Board of Health as soon as technically possible because the assessment of an impending epidemic is based on the presence of viruses in a community.

b. In all programs, attention must be given to measures ensuring adequate recording of each immunization given, including the source and lot number of the vaccines.

c. All cases of illness with central nervous system symptoms occurring in persons receiving oral vaccine or among members of the household of such persons within 21 days of the administration of the vaccine shall be reported to the State Board of Health on a form prescribed by the Board, and adequate stool specimens should be submitted for viral studies to the State Laboratory of Hygiene from such persons or their family contacts.

ROENTGEN RIDDLE

continued from page 312

DISCUSSION: The lesions as seen in the present patient are quite characteristic for cysticercosis. Cysticercosis cellulosae represents infestation of the taenia solium larvae. The usual life cycle of the adult pork tapeworm begins with the infestations of the gastrointestinal tract of the human. Ova infected feces ingested by the hog brings forth the larva form which penetrates the pig's intestinal mucosa, enters the circulation and becomes encysted within the muscles. Man then eats the measly pork containing the larvae and the adult pork tapeworm develops in the human gastrointestinal tract.

Cysticercosis in man represents infestation as a result of the ingestion of the taenia eggs and not eating larvae infected or measly pork. The soft tissue calcifications represent the nonviable cysts of the cysticercosis cellulosae. While still viable and in their early stages of degeneration they are not visible roentgenographically and unfortunately so, for this is the time clinical syndromes of cysticercosis may develop. The most common one is Jacksonian convulsions and eosinophilia. The convulsions are said to result from an endotoxin liberated as the cysts degenerate. The tissues most commonly affected with taenia solium larvae are the brain, muscles, cutis, eye, heart, liver and lung. No treatment is rendered in cysticercosis although Aspidium or male fern is used in cases of intestinal infestation with the adult taenia solium.

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Drugs in the Management of the Glaucomas

By ALBERT C. YARD, M.D., Ph.D.
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GLAUCOMA is a name applied to several distinct pathological processes which have in common an elevation of intraocular pressure. Optic nerve injury which results from the increased pressure may manifest itself as a visual field defect or blindness. Drug therapy may be the treatment of choice depending upon the etiology of the elevated intraocular pressure (P_o), but in other instances the appropriate treatment is surgical. Frequently P_o can be lowered by the use of drugs preoperatively on an emergency basis.

Intraocular pressure measured with the tonometer in the normal eye averages 15 ± 3 mm. Hg. This value is governed primarily by the intraocular volume, i.e., the volume of aqueous humor and to a much lesser extent the volume of blood in intraocular vessels. P_o can also be influenced by changes in elasticity of the globe, but this value is fairly constant in any one individual. Aqueous humor is continuously secreted by the ciliary processes into the posterior chamber and it has been estimated that the secretory process has the capability of producing a maximum P_o of 100 mm. Hg.[1] Outflow of aqueous humor prevents such a rise under normal circumstances, but resistance to drainage or actual blockade of outflow may occur. Aqueous humor must pass between the lens and the overlying iris, through the pupil, to reach the anterior chamber. It then must traverse the trabecular meshwork, a structure consisting of several perforated layers of connective tissue sheets located just anterior to the iris at the angle it forms with the cornea and sclera. Finally, the fluid enters the canal of Schlemn and is drained into intrascleral and episcleral veins.

Hindrance to outflow is the major factor causing the rise in P_o except in a rare form of glaucoma characterized by hypersecretion. The term secondary glaucoma is applied when hindrance is clearly secondary to some pathologic process, such as enlargement or dislocation of the lens, inflammation of the uveal tract, or trauma. Treatment in these cases is directed toward the underlying cause and is often surgical. Primary glaucoma, in which no specific cause is apparent, is classified as either open-angle or narrow-angle. The normal angle between the iris and cornea is 45 degrees and it is unchanged in open-angle glaucoma, which is the more common form. In the narrow-angle type, the value is 20 degrees or less. Distinction between these two forms can be made by means of special techniques available to the ophthalmologist.[2, 3]

Tonography is a recently introduced method by which outflow resistance can be quantitated and recorded. Gonioscopy is a method by which the angle can be directly visualized. Both procedures are not only diagnostic but also extremely valuable for establishing prognosis and guiding therapy. Symptoms are precipitated in narrow-angle glaucoma when for any reason the iris is forced into anterior approximation with the trabecular meshwork, occluding the pathway for drainage of aqueous humor. Most commonly this is caused by pupillary block, i.e., pressure rise in the posterior chamber resulting from a tight contact of the back of the iris against the lens. The sudden onset of blurred vision and very severe ocular pain require immediate treatment directed toward reducing P_o and relieving pain. The high resistance to outflow of aqueous humor in open-angle glaucoma not only increases P_o but is the basis for the poor adaptability in glaucoma patients to factors tending to change P_o. The site of this impairment has been postulated to be in the trabecular meshwork and more specifically, in the peripheral portion, adjacent to Schlemm's canal. This sug-

gestion is based on several types of evidence including changes in the normal architecture of the uvea, as demonstrated by electron microscopy.

Drugs can lower elevated P_o by two basic mechanisms: reduction in outflow resistance and reduction in rate of formation of aqueous humor. Parasympathomimetic agents are of several types including the naturally occurring and widely used alkaloid, pilocarpine; synthetic acetylcholine-like esters such as methacholine and carbamylcholine; and cholinesterase inhibitors such as physostigmine and the extremely potent diisopropyl fluorophosphate (DFP) and demecarium. These substances, applied locally, improve outflow facility; however, the mechanism by which this occurs is not clear, except in the case of narrow-angle glaucoma. In this type of glaucoma, in which therapy with the less potent parasympathomimetics helps prepare the patient for surgery, benefit is obtained as a result of miosis. The iris during miosis is pulled away from the structures lying anteriorly, allowing free flow once again through the trabecular meshwork and canal of Schlemm. Miotics can paradoxically worsen symptoms by increasing the degree of pupillary block, but this can usually be overcome by simultaneous utilization of antisecretory drugs. In open-angle glaucoma parasympathomimetics may provide good control for years. Tonographic data suggest that control of symptoms and prevention of visual field loss are better correlated with a good index of outflow facility than with the absolute level of intraocular pressure. Whether the main site of improved outflow facility is the trabecular meshwork or the veins peripheral to the canal of Schlemm is not clear at present.

Carbonic anhydrase inhibitors such as acetazolamide and several related compounds lower intraocular pressure when administered systemically by causing a reduction of 40 to 60 per cent in the resting rate of aqueous humor secretion. Carbonic anhydrase is known to be present in the ciliary processes and capable of catalyzing production of hydrogen and bicarbonate ions which are presumed to participate in the secretory process. However, the details of this process and also the exact derangement induced by these agents require elucidation. Carbonic anhydrase inhibitors are valuable in emergency treatment of narrow-angle glaucoma, and are widely used also in long-term control of open-angle glaucoma.

Sympathomimetics such as epinephrine and phenylephrine, when applied topically, also suppress formation of aqueous humor. Used two or three times daily, epinephrine is often of value for years. Mechanisms by which this occurs have not been established, but reduction of intraocular volume based on vasoconstriction does not appear to be important. That this effect in suppressing aqueous humor formation is different from the response to acetazolamide is shown by the observation that the rate of secretion in open-angle glaucoma can be reduced with epinephrine by an additional 30 per cent during a maximal response to acetazolamide. Sympathomimetics may act through the secondary mechanism of reducing outflow resistance under some circumstances. This dual effect has been observed especially in patients with early open-angle glaucoma treated by daily local applications of epinephrine for several months.

Hypertonic solutions of urea given intravenously to patients with acute symptoms of narrow-angle glaucoma may effectively reduce intraocular pressure when this cannot be accomplished with miotics and acetazolamide. Presumably the mechanism involved is one of reduction of fluid transfer from plasma to aqueous humor.

Although other drugs, including adrenergic blocking agents and vasopressin, have been demonstrated to lower intraocular pressure, the agents discussed above are representative of the classes of drugs now employed clinically. Much remains to be learned about the glaucomas and also about the mechanisms of benefit obtained through the use of drugs.

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EDITORIALS

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Professional Nonprofessionals

POLITICAL amateurism—the occasional participation in election campaigns by ordinary citizens—strikes terror in the hearts of party leaders. As they discovered in recent presidential campaigns, political amateurs can swing enough weight and exert sufficient influence to sway the balance with big-city bosses and political power brokers all over the country. Wilkie and Stevenson and Kennedy were candidates of political amateurism. It is evidence of the vitality of our democracy that after decades of boss-rule, the machinery of political selection can still be wrested from the professional politician by the interested amateur.

Doctors, like many other professional people, have long been prone to leave politics to the politicians. We mutter when our taxes are raised, talk bitterly about the imminence of tax-supported medicine, and rail privately at the inefficiency of our government. But when it comes to soliciting votes, ringing doorbells, telephoning, addressing letters, making speeches, we all have the ready excuse that we are too busy. And we are: we're too busy avoiding the mechanics of politics, and too often we later assume a lofty, self-righteous attitude at the results. It would be pleasant indeed if all our public servants were fine men of towering integrity and peerless efficiency. But when they aren't, whom can we blame when we made no effort to influence the issue?

It has already been pointed out that the proponents of tax-supported medicine have brought their schemes to the verge of passage into national law because they get tremendous leverage from the vote-potential of the so-called senior citizens and their sons and daughters. If you don't vote for medical care through the social security mechanism, all these votes will be against you, the legislators are told. And the only counter-balance is the somewhat polite lobbying of medical groups and their devotion to the best interests of the country.

How much more effective would be an argument against tax-supported medicine, for example, if the organized political power of citizens who recognize the evil are prepared to do something about it at the next election. This is the counterweight that senators and congressmen understand. This is the club that can clobber the machine boss whose understanding of a threat to his power is immediate and comprehensive. And the best way the argument against the

measures we don't like can be made is through the flexing of political muscle by political amateurs at the citizen level.

A few doctors in Wisconsin have already interjected themselves in political campaigns. Obviously they are not professional politicians, and they will undoubtedly withdraw from politics when the campaign is over—until the next campaign. They are to be commended, and their example is to be emulated. As doctors we have many contacts in our communities, and by the nature of our profession and our education, we command respect. Let us use those contacts, let us employ that respect to promote the welfare of our community and the stability of our nation. We have political muscle that has become flabby from inactivity. But the muscle is there; let us use it as political amateurs for the good of our country. —D. N. G.

COMMENTS FROM THE PRESS

A Day for Doc Barney?

THERE IS AN "E. W. Kracht auditorium," and now there is a testimonial dinner to Judge Carter, (both worthy men). But where is the "Salute to Dr. Barney Oldfield" day?

Have the people of Eagle River forgotten the man who delivered many of them into this world, saw them through diseases and sicknesses, and in turn delivered their children to them?

To me, Barney Oldfield is, and was, an "institution" in Eagle River. He is one of the finest and "true" country doctors. Long before your little city became a "city" and was so cosmopolitan—Barney was there, and his right hand nurse "Eva." Always in his office over the Vilas theatre, never an appointment book to go by, but willing to see one and all in his crowded waiting room. I think many of you have forgotten how much of his life and time has been given to you and yours.

Perhaps you can't appreciate these small town doctors until you live in a city. Here, your child is ill, you call your pediatrician and are told "This isn't his day to be on duty," so you must talk to another pediatrician who doesn't know the case so you relate it all over again. Treatment is prescribed by phone if at all possible. Or you are down with a bad cold and need a simple penicillin shot. This is simple? No! You must see an "internalist" and his appointment desk says "I can't possibly get you in for three or four days, by which time you hope to be well anyway. If you are pregnant, you see an "obstetrician," and if during pregnancy you develop a bladder infection you must see their "urologist."

A house call in the city is almost an impossibility —better not to consider it—and the bill would be $15.00 for the call anyway, plus the cost of any shots and medications.

Yes, you don't realize how lucky you are to have these "G.P.'s" at your disposal, to treat one and all of you. And they are good, never doubt that, as they could have chosen a specialized field in the city, but there isn't a more dedicated man than a "general practitioner" in a small town.

I for one, will not forget, Dr. Barney Oldfield, and give him my personal "salute" to a wonderful and dedicated "country doctor!"—A former "Eagle Riverite", Minneapolis, Minn. (Reprinted from the EAGLE RIVER NEWS–REVIEW, Jan. 25, 1962)

'This Is Not Prepayment'

The term "health insurance financed by social security" is literally without meaning. Insurance, by definition, carries the idea of prepayment and the condition that reserves and income of the insurer must match benefit obligations. Social security (as the supreme court and other agencies of the government have said) is not a prepayment plan. It is clearly a pay as you go program.

The implications here are obvious: Workers do not pay their our benefits. They pay the benefits of people now getting social security. Tax money of the working people would be used for the benefit of the rich as well as the poor. As the tax spirals upward, younger workers will bear a crushing burden.

Finally, how long would individuals continue to be free to arrange the remainder of their own health care? There are many strategic moves planned on the HEW chessboard but the pawns still have time to decline the dangerous game! —Connie Evrard (Reprinted in part from the MILWAUKEE JOURNAL, Feb. 25, 1962)

THE MEDICAL FORUM

House of Delegates Approves Campaign Opposing King–Anderson Legislation

Condemnation of King–Anderson legislation and proposals offered to publicly assess the dangers of such legislation were major concerns of this year's annual meeting of the State Medical Society held May 7–10 in Milwaukee. In condemning the King–Anderson type of legislation, the House of Delegates, governing body of the State Medical Society, recommended strong support for implementation of the Kerr–Mills Act.

The resolution adopted by the House stated in part: "The method of financing the proposed King–Anderson legislation (H.R. 4222 and S. 909, 87th Congress) would be through an economically unrealistic and actuarily unsound Social Security taxation system . . . the vital patient-physician relationship and the high quality medical care, now enjoyed, would be seriously injured by regimentation and bureaucratic controls . . . rapidly expanding prepaid health care plans for the aged coupled with Kerr–Mills assistance for those whose immediate resources are insufficient to meet their current health care needs is the most economic and effective method of assuring health care to all who need and want it."

Letter to Proxmire

The Council was commended by the House for its letter to Senator William Proxmire who, according to a Milwaukee newspaper, had stated that "hundreds of thousands of Americans are dying because they can't afford to live" when he addressed a meeting of the National Federation of State, County and Municipal Employees in Milwaukee recently.

The letter, signed by Dr. James C. Fox, La Crosse, chairman of the Council, stated that "This is not the truth and you know it. The fact is that millions of Americans are living in unprecedented good health because of the high quality of American medical care. Certainly you must be aware that basic health care is already available to those who need and want it.

"Your views illustrate why we of the medical profession urge continuation of our present excellent system rather than development of a system which has a history of producing poor health care.

"We believe human dignity and health can best be preserved by the system that has brought it to its present unassailable point of success, instead of substituting a system which puts health care at the mercy of political demagogues.

"On behalf of the thirty-five councilors and officers of the State Medical Society, I respectfully submit this letter for your consideration," the letter concluded.

Campaign Opposing King–Anderson

The House endorsed the Council's campaign against passage of King–Anderson legislation. Among the efforts are a statewide public information program to explain the medical profession's views on health care of the aged. Placement of advertising in daily newspapers,

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Dr. Nels A. Hill, Madison Installed as New President

Dr. Nels A. Hill, Madison, took office as president of the State Medical Society of Wisconsin in a ceremony during the Society's annual dinner May 9 at the Hotel Schroeder in Milwaukee.

As president, he will be spokesman for Wisconsin's 3,700 physicians who are members of the Society, serve on the Society's Council, and participate in all meetings of the House of Delegates.

In a talk before the House of Delegates, he outlined his aims for the Society for the coming year.

"We should continue to strive as a profession to improve the care of the aged, and to oppose expensive and impractical political solutions," he stated.

In an address to members of the Society's Woman's Auxiliary, he urged them to direct their efforts to providing homemaker's services to the aged in their own communities.

Such matters as providing hot meals, delivered to the home, and other housekeeping services would "allow ambulatory older people to

(continued on page 327)

ARE YOU LOOKING FOR YOUR GLASSES?

A pair of heavy, black-rimmed glasses (American Optical frame) were found at the State Medical Society meeting. If they are yours, quit looking for them on your forehead and write us . . . Box 1109, Madison 1, Wis.

ANNUAL MEETING HIGHLIGHT . . .

Presidential Award Given to Helen Crawford

Miss Helen Crawford, Madison, associate professor and medical librarian at the University of Wisconsin, was awarded the presidential citation of the State Medical Society of Wisconsin during the annual dinner at Hotel Schroeder in Milwaukee May 9. Dr. Leif H. Lokvam, outgoing president of the Society, made the presentation.

Miss Crawford, a native of North Dakota, came to the university in 1944.

"In the past 17 years Professor Crawford has become known and admired by faculty members and thousands of graduates as an exceptionally intelligent and capable librarian," Doctor Lokvam said.

"Through the years, while serving students of all ages and stages of education through limited facilities, she has lived with the dream which is about to be realized," he continued. The "dream" is the William S. Middleton Memorial Library planned for the medical school. He praised Miss Crawford for "developing the heart of a great library which will be worthy of the new building."

Miss Crawford is the second person to receive the presidential award of the society. The other recipient is Reuben Knutson, Madison, former chairman of the Industrial Commission.

MISS HELEN CRAWFORD GRACIOUSLY RECEIVED the Presidential Citation from President L. H. Lokvam during the annual dinner ceremonies May 9.

CAMPAIGN OPPOSING KING–ANDERSON BILL

(continued from page 325)

invitations to the public to express their opinions to their Senators, Congressmen, personal physicians and the State Medical Society, physicians to conduct personal letter-writing contacts with prominent individuals of their social, professional and business acquaintance, letters to selected organizations seeking their cooperation in opposing King–Anderson legislation, showing films, dispensing speakers all over the state through county medical societies.

The House ordered distribution of petitions to all State Medical Society members, with placards, for obtaining signatures of those opposed to King–Anderson legislation.

In another action the House urged support of the American Medical Political Action Committee (AMPAC) and the Wisconsin physicians' group—WISPAC.

Wisconsin Physicians Clarify Position on Giving Medical Care

Passed unanimously by the House of Delegates of the State Medical Society at its annual meeting was a resolution declaring that its members would at no time refuse to render medical care to any of their patients who need it regardless of what action is taken on federal proposals on health care for the aged. The action was taken to clarify the position of Wisconsin's doctors in regard to a statement by a group of 250 New Jersey physicians that they would not abide by provisions of such federal legislation.

"To the best of our knowledge the New Jersey physicians have not in fact intimated that they would refuse to render medical aid, but only that they would refuse to complete the reports or accept the payments authorized under the proposed King–Anderson bill," the statement continued.

"At no time, under any circumstances, will we as physicians refuse to render medical care to any of our patients who need it solely because of the mechanism of payment for such services."

The Society added that the action in no way lessens its criticism of King–Anderson type legislation.

Dr. Egan, Milwaukee, Elected President-elect of State Society

Dr. W. J. Egan, Milwaukee, was named president-elect of the State Medical Society at the Society's annual meeting in Milwaukee. He will assume the presidency in May of next year.

Other elections included: Dr. Robert E. Callan, Milwaukee, speaker of the House of Delegates; Dr. H. W. Carey, Lancaster, vice-speaker; Dr. L. O. Simenstad, Osceola, and Dr. E. L. Bernhart, Milwaukee, delegates to the American Medical Association; and Dr. John M. Bell, Marinette, and Dr. C. J. Picard, Superior, alternates. Doctor Picard succeeds Dr. James M. Sullivan, Milwaukee. The rest were reelected.

New members of the Society's Council, the board of directors, are: Dr. Steve L. Chojnacki, Milwaukee; Dr. Stanley W. Hollenbeck, Milwaukee; Dr. Milton Davis, Milton; and Dr. George Nadeau, Green Bay.

W. J. EGAN, M. D.

Reelected to the Council are Dr. James C. Fox, La Crosse; Dr. John M. Bell, Marinette; Dr. R. W. Mason, Marshfield; Dr. R. C. Frank, Eau Claire; and Dr. W. P. Curran, Antigo.

Achievement Award to Hayward Hospital

Hayward Area Memorial Hospital was selected by the Council of the State Medical Society, upon recommendation of its Commission on Hospital Relations and Medical Education, to receive the 1962 Hospital Achievement Award of the State Medical Society.

The award is presented on the basis of outstanding service to the community through the combined efforts of the hospital and its medical staff.

Physicians Urged to Support WISPAC

The Council of the State Medical Society has urged physicians to support the Wisconsin Professional Political Action Committee (WISPAC) which was formed recently in the state by a group of volunteer physicians. Purposes of the committee are to stimulate physicians and others to:

1. Take a more active and effective part in government affairs.

2. Understand the nature and actions of their government as to important political issues and the records of office holders and candidates.

3. Organize more effective political action in carrying out their civic responsibilities.

DR. HILL INSTALLED AS NEW PRESIDENT

(continued from page 325)

remain in their own homes and free beds in hospitals and nursing homes for the seriously ill," Doctor Hill said. He added that it would also reduce the economic problems of the aged.

"This is my idea of medical care for the aged, not money paid by social security," he concluded.

Doctor Hill also urged "expanding of our immunization programs" including a law to require smallpox vaccination for public school admittance.

Another proposal was for assistance to the State Board of Health in obtaining legislation to modernize its organization and facilities.

Pointing to past meetings with representatives of the legal and journalism professions, he recommended that they be extended to include such fields as dentistry, nursing, veterinary medicine and pharmacy.

Doctor Hill is the tenth Madison physician to become president of the State Medical Society.

News Briefs

MIDDLETON MEDICAL LIBRARY PROGRESS

Dr. Philip P. Cohen, acting dean of the University of Wisconsin Medical School, announced to the UW Medical Alumni Association that a $200,000 gift had been received from a single donor for the William S. Middleton Medical Library.

This means that construction of the first phase of the building is assured, Doctor Cohen stated.

Ground breaking, originally scheduled for May, has been postponed while application is made for a federal grant which would permit construction of a larger building.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

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- *Are you paying much more premium than you would under a comparable Time plan?*

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Approve Constitution and Bylaw Amendments

Several amendments to the Constitution and Bylaws of the State Medical Society were approved by the House. Amendments to the Constitution, while accepted this year by the House of Delegates, must be laid over for one year before they are formally adopted. Bylaw amendments are immediately in effect upon acceptance by the House.

Amendments to the Constitution are as follows:

1. Speaker of the House is to be elected for a two-year term and the Vice-Speaker is to be elected annually.
2. No constitutional officer may hold more than one office at the same time.
3. The President and Speaker of the House have the right to vote in the Council.

Amendments to the Bylaws are as follows:

1. No person shall serve on any standing committee more than three consecutive terms, nor shall any member serve concurrently on more than one such committee.

2. The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

3. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

4. When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates . . . and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year.

(Each councilor district is entitled to one councilor for every 250 members or major fraction thereof.)

ANNUAL MEETING HIGHLIGHT . . .

Citation Honors Dr. Schwade

A CITATION FOR MERITORIOUS SERVICE in furthering the employment of the handicapped has been presented in honor of the late Dr. Edward D. Schwade, Milwaukee, on behalf of the President's Committee on Employment of the Physically Handicapped. Stuart H. Becker (right above), Madison, chairman of the Governor's Committee on Employment of the Physically Handicapped, made the presentation at the opening session of the State Medical Society's annual meeting at the Milwaukee Auditorium. Dr. Lloyd F. Jenk (left), Milwaukee, accepted the citation on behalf of the Section on Psychiatry of the State Medical Society. As chairman of the Society's division on nervous and mental diseases of the Commission on State Departments, Doctor Schwade was instrumental in changing Wisconsin law to enable epileptics whose disease was under control to marry, receive a driver's license and regain many other rights denied them. He was a member of the Governor's Committee on Employment of the Physically Handicapped from 1955 until his death last year.

5. A member who removes his practice from the territory of one component county society to another may not continue his membership in the society from which he has moved after expiration of the calendar year in which such move occurred.

However, when a member in good standing in a component society removes his principal practice outside the state, he may continue his active membership in the county and state society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this state shall cease upon his acceptance by a society in the new area of practice and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

Annual Meeting Attendance

Total attendance at the 1962 annual meeting was 3,204, compared with 3,118 in 1961. Making up the total registration were 1,554 member physicians; 40 physician guests; 260 interns, residents and medical students; 577 exhibitors; and 773 guests—nurses, physicians' wives and others. The tabulation was provided by the Milwaukee Association of Commerce Convention Bureau.

Resolutions on Health Education, Safety, Hypnosis, School Health, Approved by House

Significant resolutions adopted by the House of Delegates include the following:

A SEAT BELT EXHIBIT WAS PREPARED for the annual meeting by the Division on Safe Transportation of the Commission on State Departments of the Society. It is one of the few exhibits to be prepared by a Society group. The exhibit was on display for one month prior to the annual meeting in the rotunda of the State Capitol.

Section on Dermatology

Recognized the specialty practice of dermatology as sufficiently organized in the state, with more than 40 members, that a new Section on Dermatology to the State Medical Society be added.

Pathology

Declared that the proper conduct of laboratory analyses is a medical professional responsibility and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians.

National Insurance Accounts

Recommended that the Society's insurance division, Wisconsin Physicians Service, not commit itself to acceptance of "national plans" which would tend to and might defeat local programs already proved acceptable and practical. National accounts involve those groups having a common employer but residing in a number of states and a voluntary insurance program for the aged.

The recommendation was based on the fact that Wisconsin Physicians Service has a plan of its own which provides full payment, within contract benefits and within a maximum liability, for the usual, customary and reasonable costs of physicians' services which has been demonstrated as workable, and has been acknowledged as successful; plus, the "Century Plan" for those aged 65 or over which is an excellent plan that is designed to meet the needs of the people in this state.

However, cooperation by the Society in nationally developed programs for the care of the aged was indicated to the extent that it would not submerge the identity of the "Century Plan."

Hypnosis

Appealed to the American Medical Association to assist in the control of the nonmedical use of hypnosis and that it urge all state and county medical societies to cooperate in the educational effort to explain the dangers of hypnotism for entertainment purposes.

Venereal Diseases

Authorized a study by the Society and the State Board of Health to analyze the incidence and source of venereal diseases in Wisconsin and develop an effective informational program for the medical profession.

Sports Injury Prevention

Urged physicians to participate in sports injury prevention and control programs and requested county medical societies to appoint interested physicians to serve for a full season and attend all competitive events.

Seat Belts

Advocated the use of automobile seat belts by all members and the general public.

School Health Issue

Pledged the Society's support for the promotion and distribution of a proposed special school health issue of *Today's Health* which would focus attention on the great issues of health education and practices affecting school age citizens.

R. S. Baldwin, M. D.

Commended R. S. Baldwin, M.D., Marshfield, for his devoted service to the *Wisconsin Medical Journal* and the members of the Society during the past 12 years in his capacity as medical editor.

(continued on page 332)

PROFESSIONAL BUSINESS SERVICE
207 N. Tenth Street
La Crosse, Wisconsin

Business Consultants to the Medical Profession.

Inquiries Invited

School Health and Safety Programs Approved

The report of the Commission on State Departments was accepted by the House of Delegates. In the Council's report to the House, it acknowledged its deep appreciation to the 99 physicians who serve cooperatively in the committee structure of the Commission. These physicians, the Council noted, "reside in virtually every nook and corner of Wisconsin; often drive many miles to participate in the responsibilities of our profession."

The following recommendations of the Commission were included in the report accepted by the House:

1. Recommended that the Society support the establishment of a Highway Safety Center at the University of Wisconsin.

2. Urged colleges and universities in the state to provide more extensive health education to students preparing for careers in teaching.

3. Recommended that school administrators develop modified physical education programs so that no student able to attend school be excused from physical education, but receive physical exercise to the extent recommended by the physician.

4. Urged the Society to move ahead with legislative action to amend the Statutes so as to apply the Criminal Code definition of "under the influence" to dangerous drugs as well as narcotics and alcohol as these relate to the operation of a motor vehicle.

5. Recommended that county medical societies be urged to have a panel available to fill requests from school administrators for speakers on school health, and that they encourage meetings on the community level between physicians and school administrators to discuss common problems in the health and fitness of school age children.

Asks Fiscal Note on Society Projects, Costs

The House of Delegates accepted the Secretary's report with an appreciation for the "gas pipe plumbing" which showed graphically the corporate structure and the administrative responsibilities and activities of the Society, the Charitable, Educational and Scientific Foundation, and the Realty Corporation.

Included in the report was the suggestion that a fiscal note be required as to what costs are involved, including staffing and other implementation, of new projects by the various commissions, committees and councils of the Society so that the House of Delegates can make a careful evaluation, not only of the project itself, but also of the extent to which the project should be carried out.

In this manner, financial needs and staff requirements can be better understood.

The report further stated that there would be no increase in the membership dues. State Medical Society dues are now $90.00.

Standing Committee Appointments

The President's appointments to standing committees of the Society will appear in next month's Forum.

KENOSHA COUNTY MEDICAL SOCIETY paid tribute to the retiring president of the State Medical Society, Dr. Leif H. Lokvam, Kenosha, by contributing $1,000.00 to the Society's Charitable, Educational and Scientific Foundation in his honor at the May 9 session of the House of Delegates during the Society's annual meeting in Milwaukee. Doctor Lokvam is shown above on the right accepting the check from Dr. D. N. Goldstein, Kenosha, president of the county society.

THE WISCONSIN STATE MEDICAL ASSISTANTS SOCIETY presented the CES Foundation with a check for $500.00 to be used for medical student loans. Their interest in the Foundation was appreciatively acknowledged by the House of Delegates during its May 8 session. Shown above is Mrs. Julia Logerquist, Sturgeon Bay, president of the Assistants Society, presenting the check to Dr. W. D. Stovall, Madison, president of the Foundation.

Urge Better Understanding Between Patient, Physician

In other actions by the House of Delegates, the following standing committee reports were approved:

Disaster Medical Care

Urged physicians to support and help implement the Medical Self-Help Training Program of the Civil Defense organization, designed to teach people to care for their medical needs in case of national emergency.

Military Medical Service

Reactivated this past year to handle Selective Service requests that placed 27 Wisconsin physicians on active duty.

Scientific Medicine

Commended the Commission for its impressive record of postgraduate teaching programs which were a significant contribution to the educational progress of Wisconsin physicians.

Grievances

Urged physicians to give adequate information to their patients so that no misunderstanding regarding physician services or fees would arise, thus fostering a possible grievance claim. Asked promotion of the AMA plaque, which can be secured through the State Medical Society at nominal expense. The plaque reads:

TO ALL MY PATIENTS

I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient.

Hospital Relations and Medical Education

Requested county medical societies to assist the Commission in its endeavor to increase enrollment of students in schools of medicine by appointing a member of each society to act as the medical school recruitment officer for that society. Urged closer liaison and better relationships between nurses and physicians.

Cancer

Recommended continued discussions with agencies and organizations—professional, public and private—concerned with cancer control in Wisconsin.

Recommended that the State Medical Society give full support to the excellent smoking-lung cancer program being sponsored by the American Cancer Society in Wisconsin. This program is designed to acquaint young people with the dangers of smoking in relation to lung cancer.

Public Relations and Communication

Recommended development of a cooperative program with other agencies to improve rural health in Wisconsin. Joint efforts of the State Medical Society, State Board of Health, Wisconsin Farm Bureau Federation, and the University of Wisconsin Agricultural Extension Service would be included.

County societies were invited to take note of the Dane County Medical Society Health Fair as a means by which other societies could develop an interest by young people in careers in health.

In other methods of communicating health information to the public, the "March of Medicine" radio programs played an important role. A total audience is estimated at 350,000 persons per week. Many county medical societies and individual physicians have been assisted through film bookings, loan packets, news coverage, lectures and special radio and television programing.

MRS. E. M. DESSLOCH
President, Woman's Auxiliary

THE WOMAN'S AUXILIARY to the State Medical Society, which is one of the staunchest supporters of Foundation programs, contributed $600.00 to the CES Foundation during the annual dinner of the Society members May 9. The Museum of Medical Progress at Prairie du Chien was the recipient of $100.00 and the medical student loan fund received the balance of $500.00.

CES Foundation to Direct Menominee Health Survey

The State Medical Society of Wisconsin has directed its Charitable, Educational and Scientific Foundation to make a health survey of Menominee, the state's newest county which formerly was the Menominee Indian Reservation.

"Physicians in bordering counties have carried this problem in the best traditions of the medical profession," said Dr. James C. *Fox*, La Crosse, chairman of the Society's Council, which took the action, "but it seems apparent that an over-all study of the situation is indicated."

The study would include such matters as cancer detection, screening, immunization programs, prenatal and postnatal care and similar matters.

A committee of five physicians was appointed by the Foundation trustees at their annual meeting held May 9. The committee includes:

Dr. Glen J. Steusser, Madison
Dr. Elmer P. Rohde, Galesville
Dr. Emil R. Krueger, Hayward
Dr. George Nadeau, Green Bay
Dr. Patricia F. Lanier, Kewaunee

Others interested in the problem will be asked to work with the committee, including the State Board of Health and State Department of Public Welfare.

The committee will report to the Council, which will then set up a long-range program to fill the health needs of Menominee County.

Council Appointments

Council appointments to divisions of the Commission on State Departments will appear in next month's Forum.

COMPLETING 50 YEARS OF SERVICE in the medical profession this year are 17 Wisconsin physicians who were awarded memberships in the State Medical Society's "Fifty Year Club." Pictured here are (front row) Dr. W. W. Coon, Walworth; Dr. Frank W. Lehmann, Hartford; Dr. John A. Cox, Milwaukee; Dr. William D. Stovall, Madison; Dr. Robert E. Fitzgerald, Milwaukee; (back row) Dr. Alvin G. Koehler, Oshkosh; Dr. Harold B. Keland, Racine; Dr. Arthur J. McCarey, Green Bay; Dr. William A. Joseph, West Allis; and Dr. John R. Newman, Madison. Other members not shown are: Drs. Matthew A. McGarty, La Crosse; Ernest G. Ovitz, Laona; Norman E. McBeath and Herbert F. Wolters, of Milwaukee; Vincent J. Shippy, Pulaski; Robert C. Thackeray, Racine; and William C. Maas, Rio.

Urges Statewide Policy on Oral Polio Vaccine

Other reports accepted by the House of Delegates included:

State Health Officer

Dr. Carl N. Neupert, state health officer, urged a statewide policy on the administration of oral polio vaccine and proposed federal legislation in the field of immunology. It was the House's recommendation that any such proposals be carefully reviewed by a committee of the Council and that a statement of policy be issued as a result of its study. The House further expressed its opinion that any program have its control at the local level.

Medical Examiners

The number of foreign graduates in the residency training programs in Wisconsin is diminishing, according to Dr. T. W. Tormey, Jr., Madison, secretary of the State Board of Medical Examiners. In 1959 there were 50 new applicants and 40 renewals; in 1961 there were only 28 new applicants and only 2 renewals. This indicates that the training programs and hospital patient care are suffering for lack of personnel, he added. Doctor Tormey attributed the decline largely to the requirement that they pass the examination conducted by the E.C.F.M.G. This examination is intended to assure a higher caliber individual serving in house staff positions.

In the past year the State Board issued 333 licenses or certificates, Doctor Tormey noted. At the time of his report a total registration for 1962 of 6,174 individuals was recorded. Included in this figure were 5,436 M. D.'s (4,250 in state, 1,186 out of state), 230 D.O.'s (155 in state, 75 out of state), 370 physical therapists (230 in state, 140 out of state), and 138 podiatrists (in state).

Narcotics Registration Due Before July 1

Every physician who distributes, dispenses, gives away, or administers narcotic drugs to patients must register and pay a tax of $1.00 on or before July 1.

Registration is accomplished through the Director of Internal Revenue, Milwaukee 1, Wis. Direct any correspondence to that address.

Woman's Auxiliary

The House expressed its thanks to members of the Auxiliary for their many activities and contributions on behalf of the State Medical Society and the Charitable, Educational and Scientific Foundation. Their efforts are most significant in the preservation of the voluntary health system in this country.

Medical Assistants

Acknowledgment of the interest of the Wisconsin State Medical Assistants Society in the financial needs of medical students and the generous support its members give to Society programs was expressed with appreciation.

RESOLUTIONS

(continued from page 329)

A resolution introduced by the Section on General Practice relating to surgical assistants was referred to the Council as a matter concerned primarily with ethics.

A Brown County Medical Society resolution concerning doctor-patient relationships in insurance programs was not adopted. The Reference Committee pointed out that means of resolving this problem are available under already existing administrative procedures.

the Wisconsin Medical Journal

JULY 1962

VOLUME 61

NUMBER 7

"After 20 Hours of Continuous Labor!"

By F. J. HOFMEISTER, M. D.
Milwaukee, Wisconsin

LABOR WITH significant repetitive contractions continuing beyond 20 hours is considered prolonged. Labor over 24 hours begins to indicate its potential hazards with increased fetal mortality.

Labor over 30 hours is considered by some to border on neglected labor with greatly increased hazards to the fetus. In addition, the tragedy of maternal mortality can complicate the problem as an added hazard.

Great efforts have resulted in great rewards!

Maternal mortality graphic curves, local and national in their downward tread, are a tribute to generalist and specialist. By their individual and combined efforts, physicians have effectively combated the three historically accepted major causes of maternal death: hemorrhage, infection and toxemia.

This trend of decreased mortality is also present in neonatal statistics. Greater reductions are possible since with improved obstetrical care and with reduced maternal mortality, there is also a reduction of associated fetal loss.

In just 25 short years, maternal mortality at Milwaukee Hospital has decreased from 1 death in 182 deliveries to 1 in 11,000 deliveries. Twenty per cent of these deaths of 25 years ago were associated with Cesarean section which was used as the "last hope"—after all other obstetrical "sleight of hand" procedures failed. Recently an embolic death ended a string of approximately 2,500 consecutive sections without a maternal mortality.

This record is an example of the statistical improvement that can be duplicated throughout America. It reflects the rewards of better physician preparation in medical schools, internships and residencies, and a greater physician team effort in seeking and giving consultation, and in the more frequent and intelligent use of supportive measures.

With maternal deaths dropping from 20 per 10,000 live births to 3 per 10,000 live births in the past 10 years, why the deep concern? First, complacency can never be accepted where exacting care is required. Second, 3 deaths per 10,000 live births mean that upward of 2,000 healthy women in the prime of life, 60 per cent multipara with responsibilities to another 1 to 12 children, are sacrificed each year.

Infection is regaining prominence as a cause of maternal death. Until recently, physicians leaned on the complacent reassurance of improved statistics. Since the advent of antibiotics and chemotherapeutic agents, infection deaths have decreased rapidly. How-

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Prepared at the request of the Maternal Mortality Study Committee of the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments.

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ever, within the past two years, it has not been unusual to review one or two infection problems at each maternal mortality meeting.

Devitalization of tissue, the result of trauma and associated hemorrhage, is the the significant step to overwhelming infection and death. The initiating trauma in 50 per cent of the instances is precipitated by or associated with prolonged labor.

CHALLENGE AND GOAL

The challenge and the goal: (1) to intelligently conduct the obstetrical case to prevent prolonged labor and (2) to avoid trauma.

A primigravida labor is considered prolonged after 20 hours. A multigravida is expected to deliver in about 8 to 12 hours. The time interval after which labor is designated as prolonged varies in various institutions from 18 hours (Greenhill) to 24 hours (Gainay). The late Calkins established his time limits with labor conditions, the intensity of contractions, and the position and size of infant. These time limits varied from 19 to 30 hours. The incidence of prolonged labor is accepted as existing in between 1.5 to 5 per cent of obstetrical cases.

It is necessary that the confusing problem of "false labor" is eliminated. Vaginal examination will often reveal a long uneffaced minimally dilated cervix where histories have indicated that regular contractions have existed for 10 to 12 hours. These are the Braxton Hicks contractions of "false labor." Unfortunately, the total duration of these contractions is at times erroneously considered along with the duration of true productive labor. This must be avoided.

It is necessary to establish progressive thinning and dilatation of the cervix, the result of productive frequent contractions, as an indication of the existence of true labor.

The attack on the problem of prolonged labor must begin with the initial prenatal visit. Long emphasized for its value in combating toxemia, exacting intelligently conducted prenatal care has a much broader effect on the entire obstetrical experience of women.

An essential component of this prenatal care, in addition to an accurate history and the complete physical evaluation of the woman, is the establishment of a rapport which will instill complete confidence. Knowledge of hereditary tendencies or of existing abnormalities coincidental to the pregnancy may be essential in protecting both mother and infant. The genuine interest of the physician in detecting problems through an exacting history and physical examination is the foundation upon which this confidence can be built. Continued accurate care and intelligent observation during this important prenatal period will result in the detection of conditions which may indicate the possibility of prolonged labor and often preclude vaginal delivery. This observation must include a careful evaluation of pelvic capacity, attempted estimation of fetal size, and determination of fetal presentation.

Near term, if routine evaluation indicates a failure of the presenting part to engage, or if there is indication of malformation or malposition, it is advisable to obtain an x-ray examination. This will result in determining actual measurements of fetal head as compared to pelvic inlet, midplane and outlet. The x-ray determination should be used where clinical examination indicates the suspicion of midplane contraction. Prolonged labor with its hazards as a result of undetected, undiagnosed midplane contraction will result in far greater damage to an infant than intelligently requested, expertly done x-ray evaluation at or near term. X-ray examination should be avoided in first and second trimesters. Remember, however, that x-ray techniques and interpretations are no better or safer than the man or woman behind the x-ray. All physicians have attended the patient who was doomed to section by x-ray interpretation, only to have had her deliver precipitously and most unexpectedly. All have attended the other patient who, as prognosticated by x-ray evaluation, was expected to deliver "in a breeze." This patient would still be laboring if repeated clinical examination and consultation had not pointed to the necessity of Cesarean section.

The detection of obstructing tumors of the birth canal can only be accomplished by instituting routine reevaluation of the pelvis by carefully done vaginal examinations at the fourth and seventh month of gestation and again near term. This will prevent the catastrophy of surprise and eliminate the torture of suffering through prolonged, dangerous, unproductive labor which can result from an obstructing fibroid or ovarian tumor. Remember, there is no rule which outlaws a carefully done vaginal examination regardless of the period of gestation. However,

there are many strong arguments to uphold these examinations.

Additional rewards are recognized for the patient and physician who cooperate in making each prenatal visit an intelligent evaluation of gestation progress and the patient's physical status. The patient must be placed on the table at each visit so that progress of fetal size can be noted and the fetal heart can be checked. Careful palpatation using Leopold's maneuvers will reveal errors of lie or presentation. Additional evaluation of the patient by rectal examinations will aid in the detection of abnormalities including the problem of the anencephalic infant or the hydrocephalic infant. These detected abnormalities can be conquered and hazards to mothers and infants greatly reduced. It is safe to assume that, conservatively estimated, cephalopelvic disproportion and the existence of faulty lie is a factor in 20 per cent of the instances of prolonged labor. Many unproductive prolonged labors destined to eventually terminate in Cesarean section, often complicated by fetal wastage, could be avoided by earlier detection through examination and earlier intervention.

An additional valuable weapon in the continued fight against prolonged labor can be gained by the proper personal introduction to your patient through this approach of thoroughness. This accurate interest will result in progressive psychological conditioning of this patient during the prenatal period. The quality of the seed of confidence planted by the initial impression made with your patient will grow into her recognition of full security in your care and judgment. A poor impression will create insecurity and can result in a running battle of challenging questions and continuous debate throughout the prenatal period.

Although physicians need not be swayed by the so-called "Natural Childbirth," it is essential that they recognize the important contributions made toward relaxation of patient tensions by encouraging expectant mother and parent education. Some of this can be accomplished in the physician's office, some can be done in the many well organized parent classes which are a part of your hospitals and should be a part of every hospital caring for obstetrical patients. It is the physician's responsibility to direct attention to the many safeguards that have been developed in the past 20 years and the resultant progress made in America in the reduction of maternal mortality to an almost irreducible minimum.

It is essential that young American mothers are made aware of the persistent drive of the American obstetrical team, led by you, the American physician, which has resulted in the fact that America leads all nations. This team has made America the safest place in the world in which to conceive and deliver an infant. With this knowledge, with proper parent education, with the assurance of good health as the result of adequate prenatal examination and care, the expectant mother will advance to the labor and delivery room full of confidence and relaxed to face the contractions of labor and the tremendous experience of labor as a normal process. The result will be a relaxation, which will reduce requirements for analgesic and amnesiac medication. Excessive medication will now not interfere with the effectiveness of the labor mechanisms. This will finally result in a reduction of the incidence of prolonged labor.

LABOR AND DELIVERY

When labor starts with evidence of a gush of water, a show of blood, the existence of regular contractions, or a combination of any two or three, your patient will not panic. She has been indoctrinated in what to expect. She has the assurance that she is welcome to call you or your designated associate day or night for assurance and direction. She enters the hospital with reassured confidence, and it is our hope that this will be further increased by the kind and considerate assistance of the registration personnel and the labor and delivery room staff of nurses and physicians. You, the physician, have the confidence of knowing that many of the problems of gross deformity and abnormalities have been detected and eliminated through your adequate prenatal care. As a result systematically observed labor can progress.

After it has been established that actual labor exists, you may expect the primigravida to deliver in 12 to 20 hours. You know that from 1 to 1.5 per cent of your cases will result in labor over 20 hours. This knowledge should create an alertness which will prepare you for the prolonged case when it occurs. You should be especially alert when attending patients with a dyskinetic labor,

where breech presentation exists, when premature rupture of membranes occurs associated with a long, unprepared cervix, or where malpositions exist.

When labor reaches the 20 hour period, the time which is designated as the warning signal, what is the course? Certainly this does not mean the patient must be delivered because an arbitrary danger line has been reached. It does mean that *if* delivery is not imminent, the red flare of danger has been ignited indicating the necessity for a complete patient and progress reevaluation.

This reevaluation should be systematic. It should include a review of her labor record up to that time. The intake and output of the patient should be examined and the state of hydration noted. Fluids adequate to establish hydration and nutrition should be given. The character of the contractions should be evaluated. It is well to note that 20 hours of 10 minute contractions are less significant than 20 hours of 3 minute contractions. The amount of sedation which has been administered should be determined. A careful sterile vaginal examination should be done to detect problems of position or presentation and definitely establish the degree of dilatation. The character, rate and quality of the fetal heart tones must be checked often. If the membranes are intact, an amniotomy may be indicated. Ineffectual labors have converted to productive labors in short order after membranes have been ruptured. No damage can be done if the presenting part is engaged and if the presentation is cephalic. It may be that at this time clinical indications point to the necessity of x-ray evaluation.

X-ray films should be taken and may reveal the illusive midplane contraction or a straight sacrum, or both. They may disclose malformation or disproportion, or confirm abnormal position. This reevaluation will be incomplete unless the opinion of another physician, impartial and unrelated to the problem case, is requested. The impact of consultation can be great. The consultation may result in the opinion to further adjust fluid balance, to rest the patient and later stimulate and reactivate labor with an intravenous drip of an oxytocic (Pitocin), or to actively intervene. Consultation may eliminate the confusion resulting from indecision, indecision resulting from pressure due to the physician's own commitments. These pressures or apparent obligations may result in the injudicious use of such procedures as version and extraction which, today, has only limited indications; Dührssen's incisions, which can create lasting defects unless accurately made and repaired; and traumatic forceps applications and deliveries.

Be aware of the hazards and recognize your responsibilities when oxytocics are used. Real danger may exist for the primigravida and multigravida (especially old multigravidas) with administration of stimulation. Stimulation may result in rupture of the traumatized lower uterine segment. The patient's response to stimulation may be such that tetanic contractions will result. This creates great hazards to an infant and can also result in precipitous expulsion of fetus with resultant extensive vaginal, cervical and/or uterine lacerations. It is the physician's responsibility to be available for emergency or to have a designated professional representative available to cope with any emergency and to avoid the catastrophe which can result when oxytocics are administered.

Remember, statistics indicate that after 30 hours there is progressive hazard to both mother and infant. Probably after 30 hours, we are stepping from prolonged labor to neglected labor. If reevaluation has been made at 20 hours, and progress has not been satisfactory after rest and hydration, the mode of attack should be Cesarean section. Antibiotics will have been started by 20 hours regardless of ruptured or intact membranes. It is recognized that after 12 hours of active labor, positive cultures can be obtained from the amniotic fluid even when membranes are intact and certainly when membranes have been ruptured during this period of time.

ACCURATE CARE

With intelligent observation and accurate care, the result should be excellent. The time is at hand that we recognize the necessity of an intelligent approach based on careful evaluation, and cast aside antiquated methods of obstetrical gymnastic procedures and obstetrical tricks for Cesarean section, when indicated. It is time to disregard some arbitrary statistical ceiling which has been established to regulate our judgment when confronted by the decision for Cesarean sec-

tion. Poor results by section for mother and infant will increase in direct proportion as length of labor increases beyond 30 hours. This should not mean that we are to set aside caution, policy, and indications for what some erroneously consider convenience. Sections still are associated with every hazard of major surgery. If they are performed when indicated, the overall section rate will rise beyond 5 or 5.5 per cent, and many infants will be salvaged.

The pattern of a patient's future childbearing, indeed the question of whether she will ever conceive again, may depend upon the conduct of her labor and the memory of her delivery experience. Make it a gratifying experience!

SUMMARY

An attempt has been made to indicate the necessity for persistent effort by the obstetrician to combat the entity of prolonged labor. This must start in the prenatal period by complete examination, evaluation and care, and by instilling within the patient confidence in her physician with emphasis directed to the fact that the patient who is informed and has confidence will have a naturally decreased labor time. Although seemingly contradictory, I would admonish you that complacency on the part of the physician and/or patient because of the tendency to emphasize naturalness must never be permitted to replace intelligent care by a physician well trained to observe, care for and actively intervene with Cesarean section when necessary, instead of using antiquated obstetrical tricks. It must always be emphasized that the practice of obstetrics is major surgery and that, when least expected, complications may arise which may require surgical skill, or which may result during a fleeting short moment in the elimination of a life, in fact two lives, because of faulty judgment or the use of a faulty procedure.

CONCLUSION

1. Efforts to successfully combat prolonged labor must begin with the initial visit of patient to physician.
2. Complete history and physical examination will reveal the complete physical status of patient and prepare the physician to combat any abnormalities.
3. The complete history and physical examination will impress the patient with the thoroughness and exactness of her physician and will establish a relaxation of confidence in her physician.
4. At term: Patient and physician must be aware of the exact definition of labor. "Rhythmic uterine contractions that result in progressive thinning and dilatation of cervix and eventual delivery." "Labor must be recognized."
5. A standard of time limits must be established for labor versus prolonged labor. Twenty hours seems to be a logical deciding point between normal labor and prolonged labor.
6. What should 20 hours mean?
   A. IT DOES NOT mean delivery should occur.
   B. IT DOES MEAN an inventory must be taken.
7. What is this inventory? Evaluation of:
   A. Type and timing of contractions.
   B. Medication used and dosage.
   C. Status of fetal heart tones.
   D. Hydration.
   E. Status of bladder.
   F. Antibiotic coverage in labors extending between 12 and 20 hours as indicated.
   G. Findings of vaginal examination.
   H. Status of membranes—ruptured or intact?
   I. X-ray evaluation. This is a most valuable time for x-ray examination.
   J. CONSULTATION!
8. Method of delivery must depend upon reevaluation.
   A. Rest, hydration and later stimulation may be the answer to vaginal delivery.
   B. Reevaluation may indicate Cesarean section to be the method of choice.

REMEMBER—Every hour over 24 hours takes an increased fetal toll. After 30 hours, prolonged labor can often be considered neglected labor with an increased maternal toll added to the increased fetal toll.

2212 West State Street.

Premature Ruptured Membranes

By F. J. HOFMEISTER, M. D.
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THE INCIDENCE of maternal mortality has been greatly reduced in the past 10 years and repeated studies seem to indicate that the problem of infection has been practically conquered. However, there is hardly a Maternal Mortality Committee meeting at which a case having its mortality directly associated with infection is not considered. It is interesting to note that this infection process has recently been more frequently associated with premature ruptured membranes either with vaginal delivery or Cesarean section. It is also interesting to note that in the recent past several deaths have been recorded where either unrecognized ruptured membranes have existed but no set predetermined method of management had been established. It is, therefore, advisable that the entire problem of premature ruptured membranes be considered.

PREMATURE ruptured membranes can be defined as rupture of the membranes occurring before the onset of labor. The overall recognized incidence of this condition is between 10 and 12 per cent. When ruptured membranes coexist with premature infants and as a prelude to premature labor, the incidence rises to 17 per cent or more. It is significant that where ruptured membranes exist at or near term, labor usually follows rather rapidly and occurs in less than 24 hours. It is also significant that these labors are usually recorded as being shorter. However, if rupture of the membrane occurs prematurely in a situation where the infant is less than 2,500 gm., this lag or latent period between the time of rupture of membranes and the onset of labor is usually longer. Therefore, we are dealing with two distinct entities: (1) rupture of membranes prematurely at or near term and (2) rupture of membranes prematurely with an infant that is premature in size weighing less than 2,500 gm. The latter will be discussed first.

When premature rupture of the membrane exists at approximately the thirtieth or thirty-second week of gestation with a small infant, it is our desire to attend this incidence with conservatism in an attempt to prolong the pregnancy to such time as the infant can be salvaged. There must be minimal examination procedures to establish the diagnosis, since the sudden gush of fluid from the vaginal area may not be amniotic fluid but could conceivably be involuntary loss of urine. The chemical test, bromthymol blue, to detect amniotic fluid leak may be used. However, this patient deserves the benefits of an examination. A speculum examination is in order, together with gentle vaginal and rectovaginal examination. It is at this time that one can detect the irritability of the uterus, the effacement of the cervix, the length of the cervix, the degree of the dilatation of the cervix and the presence or absence of a prolapsed cord. Prolapsed cord is an infrequent complication, but it will determine specifically the necessity for active intervention. Once the cord is prolapsed into the vagina, the chance for expectant therapy resulting in salvage of infant is eliminated.

Active stimulation for the evacuation of a fetus is the method of choice unless the fetus is of such a size that Cesarean section could result in a live infant. One could not quarrel with the physician who would take a culture in anticipation of the use of antibiotics. However, it must be emphasized that the culture swab must be placed into the cervical os, not through the internal os for this certainly would stimulate labor. It must be a cervical smear since a vaginal smear will not be of value. A smear could be valuable if infection were present or anticipated. However, a negative smear at this particular time does not insure one that there could be no subsequent infection.

Prophylactic antibiotic and chemotherapeutic agents have been frowned upon since the report of the study by Gilbeau and East-

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man has been available. In our management and in the management of most obstetricians, the premature ruptured membrane coexistent with the premature infant case is not covered with antibiotic therapy or chemotherapeutic agents until such a time when the decision is made to either actively deliver the patient vaginally or through the abdominal route. At the time labor begins or when intervention is carried out, the patient must be fortified with antibiotics; and it is suggested that 1,000,000 units of regular penicillin followed by 400,000 units of aqueous fortified penicillin be given every eight hours. The patient should also be placed at bed rest under observation in a hospital for a period of several days. If labor does not occur, the patient may be returned to her home and advised that rest is necessary, that coitus must be avoided and that the insertion of any douche tip or any foreign body into the vagina must be avoided. Examinations vaginally or rectally must be avoided unless essential for the welfare of the patient during this period of conservatism. The patient must be warned that with the onset of anything unusual, the doctor must be contacted. This may include fever, foul discharge, bloody show or cramps. If the patient is admitted with evidence of a foul discharge and a fever, this might indicate the existence of amnionitis. The patient should have her record checked to determine whether an initial smear was taken. If it was, the report of this smear and its sensitivity reaction should be employed for determining initial therapy. However, another smear should be taken from the cervical os to identify the existent infection and a sensitivity test should be set up immediately. The patient should be placed on a more energetic program of antibiotic therapy. Under these circumstances intravenous fluids, blood—if necessary as indicated by the blood cell count or shock, and intravenous penicillin in doses from 10 to 30 million units should be given. It is suggested by some that 0.5 gm. of streptomycin be given several times daily along with the penicillin. Others have used from 1 to 5 gm. of chloramphenicol (Chloromycetin) in order to establish broad spectrum coverage. The usual organism identified with this particular situation is the anerobic Streptococcus. The patient, if not in active labor, should be stimulated carefully. Dr. Gordon Douglas indicates that he has had no difficulty with posterior pituitary injection (Pituitrin) stimulation in spite of the existent intrauterine infection. When infection is present, recovery depends upon evacuation of the uterine contents.

What of the situation where rupture of the membranes occurs at or near term? Only in 10 per cent of these cases will the lag period be longer than 48 hours. Most will fall into the 80 per cent with a labor lag of less than 24 hours. Labor usually occurs spontaneously and without the necessity of stimulation. However, since the membranes have spontaneously ruptured and since the patient is at term, one could not quarrel with the physician who would use Pituitrin stimulation if it were not otherwise obstetrically contraindicated. If the membranes are ruptured in excess of 12 hours and labor has not started, the patient should be fortified with antibiotic therapy along the conservative lines as previously described—one million units of penicillin followed by 400,000 units every 8 hours. If the lag of the onset of labor exceeds 24 hours in spite of intravenous drip stimulation with 5 minims of oxytocin in 500 ml. of fluid, one would certainly be justified, supported by the study by Keith Russell, to consider emptying the uterus by Cesarean section. In his article about to be published he indicates that the patient at term should be delivered vaginally or abdominally within 18 hours after rupture of membrane. We would not be that radical but would not disagree with someone who did this after 24 hours of ruptured membranes without stimulation being effective. Certainly if this condition exists beyond 48 hours, the uterus should be emptied by Cesarean section. For the mortality rate associated with this procedure is much lower than that associated with a neglected, erroneously treated case that is permitted to continue with prolonged ruptured membranes at or near term.

If the patient entered the hospital at or near term with evidence of intrauterine infection, fever, chill, abdominal tenderness and no labor, she should be treated by direct inspection of the cervix. A swab must be taken for determination of the infecting agent. This swab must be taken directly from the endocervical canal. Cultures should be made for identity of the organism and for sensitivity determination. Antibiotics should be started in massive amounts from 10 to 30 million units of penicillin and 1 to 5 gm. of chloramphenicol by the intravenous route in drip administration. At the same time this

patient should have the benefit of immediate attempts to empty the uterus by oxytocin drip stimulation if not contraindicated by the obstetrical status or by the history of a previous Cesarean section. When there is frank infection, it has been shown by Kobek that the low cervical Cesarean section is still the safest. Dr. Gordon Douglas and his group indicate that where frank pus is found in the uterus, the patient will benefit by a Cesarean hysterectomy more than by an attempt to close the uterine cavity and establish drainage. Adequate antibiotic coverage is mandatory.

SUMMARY

An attempt has been made to outline the methods of conducting the obstetrical case with premature ruptured membranes; that is, rupture of membranes before labor associated with the premature infant and premature ruptured membranes associated with a patient who has a pregnancy near or at term. It is important that when premature ruptured membranes exists, a definite plan of management must be initiated.

2212 West State Street.

Influence of Anesthetic Agents in the Newborn Infant

By WILLIAM KREUL, M. D.
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All analgesic, sedative, tranquilizing and anesthetic drugs are depressing and, alone or in combination, can lead to the anesthetic state. The total depressant effect of all that are administered to the mother must be considered in the welfare of the unborn child.

The best interest of mother and child are opposed. The mother needs the help these depressing drugs offer, but the infant needs stimulation rather than depression. The mother is entitled to help but not to the point of jeopardy to her child. Nor does she need that degree of drugging. The danger lies with inappropriate drug and dose.

When analgesics are used to control apprehension, respiratory depression is excessive. When sedatives and hypnotics are used to control pain, cerebral and cardiovascular depression becomes inordinate.

Minimize the total depressant effect by administering the appropriate drug, and dose of the drug chosen, to control the symptoms—analgesic for pain, sedative for rest, tranquilizer for apprehension. Combinations will be necessary in most cases but individualization is essential.

In addition, liberal doses of T.L.C. (tender loving care) should be given by the obstetrician and his nursing staff. Depression does not accompany its use. Excessive doses are difficult if not impossible to administer. T.L.C. saves on drugs.

Pain is a very personal experience. Pain is enhanced by worry, resentment, anxiety, anger, apprehension. The treatment of pain can tax the ingenuity of the physician and constitutes one of the great challenges of everyday practice.

Of all the possible combinations of anesthetic agents and techniques, the most generally acceptable, the most versatile and safest for mother and child, is nerve block (pudendal block and/or local infiltration) with nitrous oxide inhalation. The control of pain peripherally in preference to centrally obviously upsets physiology less. Every physician doing obstetrics should be able to perform a pudendal block. Nitrous oxide is inert, rapidly effective, a good analgesic in concentrations of 30% to 50%, capable of producing unconsciousness in concentrations of 40% to 70%, and rapidly excreted by exhalation.

Saddle block spinal anesthesia performed in the sitting position at the level of the crests of the ilium or lower, using dextrose weighted solution in low dose, is statistically proven safe for mother and child. However, hypotension may occur and present a threat to the infant. Therefore, frequent blood pressure readings should be taken to promptly identify a drop. Treatment is administration of oxygen and of a vasopressor.

Nerve block-nitrous oxide sequence and saddle spinal both provide satisfactory maternal conditions with no depression of the infant.

Summary of a presentation at the Conference on Problems of the Newborn, St. Vincent's Hospital, Green Bay, Jan. 18, 1962.

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Prolapse of the Uterus as a Complication of Pregnancy

By JAY A. LARKEY, M. D. and YASAR ATAMDEDE, M. D.
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PROLAPSE OF the uterus in pregnancy is a rare complication. The earliest reference to this condition is in *The Anatomical Exercitations* by William Marvey[1] in 1653. Up to 1956, only 194 cases had been reported.[2] Keettel[3] in 1957 added 4 more, and in 1941 he estimated it occurred once in 13,000 deliveries. Kibel[4] estimated 1 in 15,696; Marcus and Brandt[5] reported 1 in 11,237. During the 10 years, 1948 to 1958, 2 cases of second degree prolapse were seen among 25,000 deliveries at Mount Sinai Hospital.[6] A third case was seen at the same hospital in 1961.

The descent of the uterus is usually expressed in degrees: in first degree prolapse the cervix appears at the vulva; in second degree, the cervix extrudes; and in third degree, or procidentia, the entire uterus is found outside the vulva. Prolapse is seldom seen in primigravida. The relaxation and laceration of the supportive uterine fascia and ligaments during labor is responsible for the descent of the uterus in subsequent pregnancies. If the condition exists prior to pregnancy, it will be accentuated during pregnancy. It will remain annoying or incapacitating until the uterus rises from the pelvis, usually in the fourth or fifth month of pregnancy.

Between 1892 and 1949, 176 cases were reported.[7] The rate of abortion was about 15 per cent among these patients. The fetal death rate was 18 per cent and maternal death rate was 4.03 per cent. (Table 1). Since 1925 there has been no maternal death, and since 1948, no fetal death.

The antepartum management of each patient must be individualized, but in general the following procedures have been advocated: (1) proper use of pessaries, (2) bed rest with elevation of the feet, and (3) antiseptic measures to prevent infection of the protruding cervix.

The obstetrical management of each patient is also individualized with either spontaneous or low forceps deliveries and Duhrssen's incisions when indicated. Surgical correction is reserved until after the postpartum period. Israel and Weber[8] have said, "From the standpoint of obstetrical management, it is only of academic interest whether the prolapse antedated the pregnancy or developed after its onset; whether it is really uterine prolapse or merely an elongation of the cervix; or whether the prolapse persists after the postpartum period or corrects itself, for if the cervix presents itself at the vulva, the obstetric problem remains the same."

Table 2 is an analysis of cases of second degree prolapse reported during the past 10 years. It includes antepartum and immediate postpartum treatment. It is interesting to note the change in method of delivery that has taken place over the years.

CASE REPORTS

Case 1—A 40-year-old gravida V, para II, white woman was first seen in January, 1958. Her last normal menstrual period had begun two months before. She complained of breast enlargement, frequency of urination and early morning nausea. For three days prior to her visit, she noted something protruding from the vagina when she stood; this mass receded when she was recumbent.

TABLE 1—*Prolapse of the Uterus in Pregnancy 1892–1949*

Number of cases	176	
Plastic repair during pregnancy	9	(prior to 1912)
Abortions	22	
Spontaneous deliveries	70	
Forceps	38	
Version	8	
Craniotomy	11	(prior to 1925)
Cesarean section	2	
Vaginal section	1	
Duhrssen's incision	41	
Fetal death	33	
Maternal death	9	(prior to 1925)

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TABLE 2—*Summary of the prolapse of the uterus in pregnancy for the last ten years*

Author	Age	Parity	Trimester of Prolapse	Antepartum Treatment	Labor	Delivery	Postpartum Treatment
Klawans and Kanter	31	I	3rd	Smith Hodge pessary	13 hr.	Spontaneous	Pessary
	29	I	2nd	Pessary	9 hr.	Spontaneous	Pessary
	24	I	2nd	Pessary	5 hr.	Spontaneous	Pack
	33	III	1st	Pessary	3 hr.	Spontaneous	Pessary
Yellen and McNeill	27	III	2nd	Bed rest	9 hr.	Forceps and Duhrssen's incision	Pack
	39	I	1st	Novak ring	22 hr.	Forceps	Pack
Vigilante and Behringer	32	I	1st	Trendelenburg and antiseptic solution	5 hr.	Spontaneous cervical tear	Antibiotics
London, et al.	33	I	1st	Rubber doughnut pessary		Spontaneous	
Gaetane and Labriola	27	I	1st		10 hr.	Forceps and Duhrssen's incision	
	25	II	3rd		3 hr.	Spontaneous	
Mufarrij and Keettel	47	I	3rd	Bed rest, saline dressings	6½ hr.	Spontaneous	
	23	II	3rd	Bed rest, Trendelenburg, Glycerine, Mercurochrome packs	1½ hr.	Spontaneous	
	31	V	3rd			Spontaneous	
		VIII	3rd	Bed rest		Spontaneous	
Larkey	40	II	1st	Gellhorn pessary, aqueous Merthiolate solution	4 hr.	Spontaneous	Antibiotics (Vaginal hysterectomy)
	42	III	1st	Gellhorn pessary at 32 weeks	3 hr.	Spontaneous	
	29	II	1st	Gellhorn pessary, aqueous Merthiolate solution		Spontaneous	Vaginal hysterectomy

She had been delivered of a full-term 6 lb. 3 oz. infant by breech extraction in 1939 after a 24-hour labor. In 1945, she was delivered of a 7 lb. infant by breech extraction after a 24-hour labor. In 1949 and in 1955, she aborted at the end of the first trimester. On both occasions the spontaneous abortions were incomplete and the uterus was curetted.

She weighed 160 lbs. and her blood pressure was 110/70 mm. Hg. She had a relaxed perineum with a moderate cystorectocele. The uterus was enlarged to the size of an 8 to 10-week gestation and the hypertrophied cervix protruded through the introitus. (Fig. 1a and 1b). There was no evidence of erosion or ulceration.

Her hemoglobin level was 14 gm. per 100 ml., serology was negative and Rh factor CDE negative, but no antibodies were detected.

Fig. 1a and 1b—These illustrations show the hypertrophied cervix protruding through the introitus.

The vagina and cervix were cleansed with green soap and aqueous Merthiolate, the procidentia reduced, and a 2½-inch Gellhorn pessary was inserted. (Fig. 2). This subsequently fell out and a 3-inch pessary was inserted.

At intervals of two weeks the pessary was removed, vagina and cervix cleansed, and the pessary reinserted. When this patient was 18 weeks pregnant, the uterus remained in position and the pessary was no longer needed.

During her prenatal course there was no proteinuria, edema, hypertension or excessive weight gain. She had gained 10 lbs. up to 38 weeks of gestation. In the last trimester, on two occasions, no Rh antibody titre was found. The heart tones remained of good quality, fetal activity was normal, and the uterus approached the xiphoid two weeks prior to her date of expected confinement.

At 39 weeks gestation the patient no longer felt fetal activity and no fetal heart tones were heard. X-ray examination of the abdomen the same day was reported as follows: The flexion of the fetal spine was increased, and while not specific and not marked, suggested the possibility of fetal death. A small gas bubble was seen within the cardiac region. It was not possible to determine whether this was from gas in the heart chamber or in an overlapping loop of intestine.

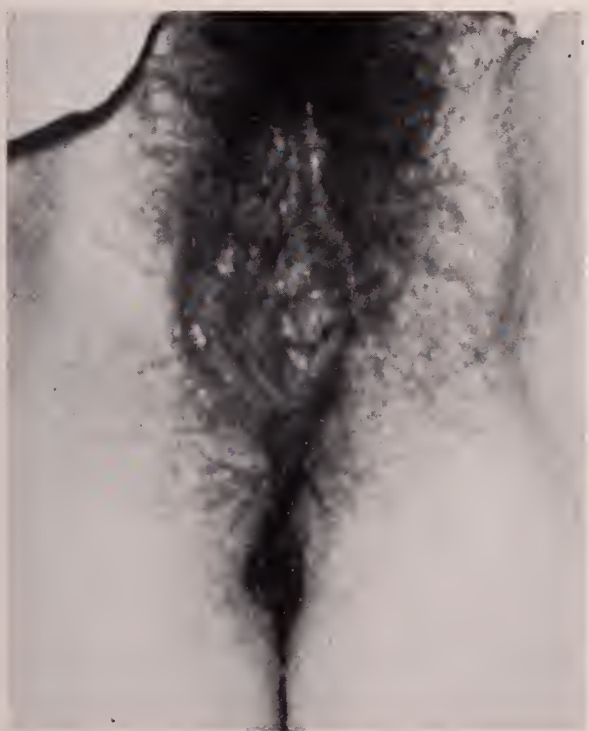

Fig. 2—This illustration shows the procidentia reduced and a 2½-inch Gellhorn pessary inserted.

Five days later the x-ray examination of the abdomen was reported as follows: There was evidence of overlapping of the cranial bones and further increase in flexion of the spine. A gas bubble over the cardiac area was again noted indicating gas in the heart, one of the signs of fetal death.

During the next four weeks the patient lost 7 lbs., the uterus diminished in size to four fingerbreadths above the umbilicus, and the breasts decreased in size. The cervix remained long, thick, and undilated. No abnormality of the blood-clotting mechanism developed.

Five weeks following intrauterine fetal death, the patient was admitted to the hospital. She had a tumor of pregnancy three fingerbreadths above the umbilicus, no fetal heart tones, normal pulse, blood pressure and temperature. All laboratory work was within normal limits. The plasma fibrinogen levels were 360 mg. and 371 mg. per 100 ml.

Two ounces of castor oil were given, an enema was administered later, and after four hours diluted oxytocin (Pitocin) was administered intravenously at a rate of 12 drops per minute. The solution contained 5 units of Pitocin in 500 ml. of 5% dextrose in water. During the induction, mild, irregular contractions occurred; but there was no change in the cervix. The Pitocin was discontinued after seven hours and contractions ceased. Two hours later the contractions became irregular, and active labor followed with progressive dilatation and effacement of the cervix. The cervix during labor did not protrude through the introitus.

After a three-hour and 50-minute first stage, the patient under inhalation anesthesia, delivered spontaneously a 5 lb. 1 oz. macerated fetus. The third stage of labor was normal and blood loss was minimal. The placenta showed gross evidence of massive infarction.

The pathology findings revealed unduly hyalinized and infarcted placenta suggestive of much earlier partial separation.

Immediately postpartum, the cervix protruded through the introitus, but two hours later it had receded.

The postpartum course was uneventful. The patient was given 600,000 units of penicillin daily. The cervix came to the introitus

when the patient walked but did not protrude from the vagina.

The patient was readmitted in February, 1959, for a vaginal hysterectomy and anterior and posterior repair. The surgical specimen consisted of a uterus and cervix 15 cm. in length. The cervix was 9 x 5 cm. in diameter, and uterus 6 cm. The uterine wall contained several leiomyoma nodules 0.3 to 1.0 cm. in diameter. The endometrium was in the presecretory and secretory phases.

Case 2—A 42-year-old gravida IV, para III, white woman whose expected date of confinement was May 24, 1955, was admitted to the hospital on December 21, 1954, primarily for evaluation of her cardiac status. Her blood pressure was 230/120 mm. Hg., pulse 105, and regular. A grade 3 systolic murmur was heard at the aortic and apical areas, and her lungs were clear. There was no dependent edema, but marked varicosities of the right leg were noted.

The fundus of the uterus was three fingerbreadths below the umbilicus. There was a prolapse of the anterior vaginal wall, and a second degree prolapse of the cervix.

She had been delivered of three children 16, 18 and 19 years before. The largest was 7 lbs. 12 oz. at birth. The deliveries were normal. Electrocardiographic findings were compatible with heart strain on the left side and myocardial damage. She remained in the hospital 14 days for treatment of her cardiovascular disease.

She was followed in the outpatient clinic jointly by the obstetrical and medical resident staff. The prolapse was treated by bed rest intermittently, and the cervix remained above the introitus. At 28 weeks gestation she was readmitted to the hospital because of vaginal bleeding. The uterus was the size of a seven-plus month gestation. The cervix was soft and patulous, and digital examination caused no bleeding.

On her second hospital day, the cervix prolapsed through the introitus, and a Gellhorn pessary was inserted. On the sixth hospital day there was no evidence of bleeding, the prolapse was controlled by the pessary, and the patient was discharged to her home.

She was readmitted on April 6, 1955, with ruptured membranes. She went into active labor 36 hours later, and delivered spontaneously a premature infant without anesthesia. The first stage of labor was 2 hours and 40 minutes, and the second stage was 5 minutes. The placenta was partially separated. The uterus was prolapsed immediately after delivery only with abdominal pressure. The patient was discharged one week after admission.

On examination six weeks later, second degree prolapse of the cervix with a third degree cystocele was present. Vaginal hysterectomy and a plastic repair were advised, but the patient refused. One year later she was seen again with the cervix at the introitus and herniation of the bladder through the introitus. The patient again refused treatment.

Case 3—A 29-year-old gravida III, para II, white woman was first seen in May, 1960. Her last menstrual period had begun two months before. In 1954, she had been delivered of an 8 lb. 12 oz. infant and in 1958 of a 10 lb. 6½ oz. infant. Both deliveries were made by low forceps rotation from occiput posterior position after 5½-hour labor periods.

Examination revealed the cervix protruding through the introitus. The uterus was 8 to 10 weeks gravid. The vagina was cleansed with aqueous Merthiolate, the prolapse reduced and a 3-inch Gellhorn pessary inserted. At three-week intervals, until the patient was 20 weeks pregnant, the pessary was removed, cleansed and reinserted.

On December 19, 1960, the patient was delivered spontaneously of twins, the first weighing 6 lbs. 10 oz. and the second, 7 lbs. 8 oz. Her postpartum course was uneventful. The cervix did not protrude from the vagina.

Nine months later she complained of backache, frequency of urination and protrusion of a mass from the vagina. A second degree prolapse was present. A vaginal hysterectomy was performed three weeks later. Her postoperative course was uneventful.

COMMENT

According to Pritchard,[9] hypofibrinogenemia frequently develops, associated with death of the fetus at 16 or more weeks of gestation, followed by intrauterine retention of the dead fetus for 5 weeks or more. He also states that labor, either spontaneous or induced, and maintained by Pitocin, except perhaps rarely, does not significantly change the level of circulating fibrinogen, even if there is a preexisting hypofibrinogenemia.

It was important with the patient in Case 1 to empty the uterus before hypofibrinogenemia developed. We considered performing a total abdominal hysterectomy and attaching the vaginal cuff to the rectus muscle. However, because of the associated cystorectocele, delivery from below with eventual vaginal plastic repair and hysterectomy, or Manchester–Fothergill operation, was considered the procedure of choice.

The cause of fetal death was asymptomatic placental separation of undetermined origin. We do not believe it was related to the prolapse or to Rh incompatibility.

SUMMARY

One hundred and seventy-six cases of prolapse of the uterus as a complication of pregnancy were reported up to 1949. Fourteen have been reported since then; we are adding three more. With the proper use of pessaries, bed rest, and the prevention of infection, the patient can be carried through pregnancy with no threat to her life. The chances of delivering a viable infant, not good in former years, have improved in the last decade. Among the 176 cases reported prior to 1949, the rate of abortion was about 15 per cent and the fetal death rate was 18 per cent; the maternal death rate was 4 per cent. In the cases studied since 1949, the abortion and fetal death rates were much lower. No maternal deaths were reported since 1925.

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Infections of the Newborn Infant, Drugs Utilized, and Their Contraindications

By THOMAS V. GEPPERT, M. D.
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The common organisms involved in infections in the newborn nursery are Streptococcus, Staphylococcus and Escherichia coli. These same three organisms are involved, whether the infant has pneumonia, meningitis, gastroenteritis, skin infection, or other organ involvement. Obviously other bacteria may be involved, but these three are by far the most common.

The treatment of choice would be an antibiotic that would adequately cover these three bacteria. It might be advisable in some instances to use prophylactic medications that would combat these three organisms. The drugs of choice would seem to be penicillin and chloramphenicol in combination. Penicillin is safe at this time, but caution is necessary with chloramphenicol. There is a rare danger of agranulocytosis or aplastic anemia, and a rather common involvement (in the infant) of the so-called gray sickness, or cyanosis and heart failure with peripheral vascular collapse and death. This essentially eliminates its use. The sulfonamides, acetylsalicylic acid, caffeine, sodium benzoate, vitamin K, and many other drugs interfere with the combination of bilirubin with albumin and consequently leave more free indirect bilirubin in circulation to increase markedly the chances of kernicterus.

Summary of a presentation at the Conference on Problems of the Newborn, St. Vincent's Hospital, Green Bay, Jan. 18, 1962.

Doctor Geppert is assistant clinical professor of pediatrics, University of Wisconsin Medical School.

Endotracheal Intubation in Resuscitation of the Newborn

By WILLIAM KREUL, M. D.
Racine, Wiscansin

SUCCESSFUL resuscitation of the newborn requires early evaluation, 60 seconds or less after birth. The Apgar rating method (Fig. 1) is an excellent device for doing so. A sizeable copy of the chart posted in the delivery room instils an awareness in all.

SIGN	0	1	2
HEART RATE	ABSENT	SLOW (BELOW 100)	OVER 100
RESPIRATORY EFFORT	ABSENT	SLOW IRREGULAR	GOOD, CRYING
MUSCLE TONE	FLACCID	SOME FLEXION OF EXTREMITIES	ACTIVE MOTION
REFLEX IRRITABILITY	NO RESPONSE	CRY	VIGOROUS CRY
COLOR	BLUE, PALE	BODY PINK, EXTREMITIES BLUE	COMPLETELY PINK

Fig. 1—Apgar Scaring Chart

Newborns rated at Apgar 3 or less are candidates for immediate tracheal intubation and artificial respiration. This immediacy is facilitated by:

(1) an open-end crib (Fig. 2) containing
(2) a laryngoscope with pencil handle and premature blade,
(3) suction catheters, and
(4) plastic Cole endotracheal tubes (Fig. 3), obtainable in sizes French 8, 10, 12, 14, 16, 18. This equipment should be in the delivery room ready for use at all times.

A newborn rated at Apgar 3 or less deserves:

(1) prompt visualization of the larynx using the laryngoscope,
(2) removal by suction of mucus, blood or amniotic debris that may be obstructing the larynx,
(3) intubation of the larynx with a Cole endotracheal tube to establish a patent airway and
(4) mouth-to-endotracheal tube artificial respiration.

The ability to intubate the newborn is now mandatory for every doctor practicing obstetrics. Skill should be obtained by practice on the stillborn. A manual, entitled "Resuscitation of the Newborn" based on the recommendations of the Special Committee on

Fig. 2—Open-end crib fixed to mobile utility table.

Prepared at the request of the Maternal Mortality Study Committee of the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments.
Doctor Kreul is anesthesiologist, St. Mary's Hospital.

Fig. 3—Fram left: laryngoscape handle with premature blade, plastic arapharyngeal airway, small bare plastic endotracheal tubes (graduated sizes) and a rubber suctian catheter.

Infant Mortality of the Medical Society of the County of New York, is obtainable without charge from the Smith, Kline and French Laboratories, Philadelphia. Arrangements for showing the medical motion picture from which the manual is adapted may be made with the local representative of the SK&F Laboratories. Both are highly recommended.

100–12th Street.

PREMATURITY AND THE CONDUCT OF LABOUR

ROUTLEDGE, J. H., and MACARTHUR, J. L., Department of Obstetrics and Gynecology, Montreal General Hospital, *Canadian M. Ass. J.* 84: 992 (May 6) 1961.

Salvage (of the premature baby) previously limited to the neonatal period, must begin earlier and become the responsibility of the obstetrician. Anoxia, cerebral trauma and sepsis are the major causes of fetal wastage during the natal period. Anoxia with its associated sequelae of atelectasis, hyaline membrane disease, and cerebral hemorrhage are best prevented by minimal analgesia, thoughtfully administered anesthesia, gentle and slow vaginal delivery, with use of episiotomy and outlet forceps when indicated.

The factors proven to increase the hazards of anoxia include Cesarean section, precipitate delivery, and faulty management of the second twin. Cerebral trauma is largely preventable by gentleness in spontaneous delivery, a generous episiotomy, and the use of "slow-down" forceps in precipitate delivery. In breech delivery the Burns-Marshall maneuver and slow delivery of the head are advocated.

The prevention of fetal sepsis, where rupture of the membranes has occurred, begins before birth with the administration of antibiotics to the mother. After delivery, care of the premature depends upon the presence or absence of respiratory effort. Where this is present even to a poor degree, oxygenation, warmth and minimal handling suffice.

For the child who cries vigorously within a minute or two of birth, oxygenation consists of placing the baby with its head inclined downward in a preheated incubator with an oxygen flow of 2 to 3 liters per minute. For the child who does not cry or establish proper respirations promptly, 100% oxygen is given by mask through the inhalator. Where apnea is present, tracheal suction followed by mechanical resuscitation is advocated.

CESAREAN SECTION — A Changing Concept

SESKI, ARTHUR G. and BERNSTEIN, CHARLES M., Department of Obstetrics and Gynecology, Woman's Hospital, Detroit, Mich., *Journal of the Michigan State Medical Society*, 61:210 (Feb.) 1962.

Drs. Arthur G. Seski and Charles M. Bernstein of Detroit reported a series of 500 consecutive Cesarean sections in the February, 1962, *Journal of the Michigan State Medical Society*. No sedatives were given preoperatively. All 500 patients received a spinal anesthetic consisting of approximately 7 mg. Pontocaine and nothing more until the cord was clamped. The anesthetic was satisfactory in all cases.

There was no maternal mortality. The uncorrected perinatal mortality rate was 5.2%, corrected to 0.9%, which is 0.4% greater than the corrected perinatal rate for vaginal delivery.

Premature infants resulted in 2.4% of Cesarean sections performed electively. It was implied that this error could be lowered by consultation, especially before the initial Cesarean section.

The overall infant mortality rate could be improved by performing Cesarean sections more liberally when a patient is at term and there is a breech presentation.

The authors concluded that in order to take full advantage of these favorable statistics, it is necessary to anticipate complications and perform Cesarean sections before these arise.

Abnormal Position of the Fetus

By G. S. KILKENNY, M. D.
Milwaukee, Wisconsin

Breech as the presenting part, occurs in 3 to 4 per cent of all deliveries and should be considered a pathological problem. It is true that with an adequate pelvis and an average size baby, and with skillful hands and judgment, delivery can be performed with no greater risk to mother and baby than in a normal vertex. But be on the alert for:

1. The larger-than-average infant in a borderline or small pelvis.
2. The hydrocephalic head, which often results in a breech presenting.
3. Extended arms which may give great trouble and which may result from too rapid delivery of the body and trunk of the infant.
4. It is unwise to perform amniotomy before the breech is deeply engaged in the pelvis, because of the likelihood of prolapse of the umbilical cord.
5. Where the legs and thighs are both flexed, it is better to permit a longer second stage for the decomposition to occur spontaneously (unless the fetus is small and the pelvis big); otherwise severe cervical and vaginal wall lacerations can occur.
6. External podalic version has its dangers. If the pelvis is adequate for the fetus, leave them alone.
7. With a foot prolapse, do not attempt to deliver until the cervix is fully dilated.

Transverse lie of the fetus is somewhat more rare than breech presentations. It is always hazardous and requires special judgment and management.

1. It is most likely to occur in the flat type pelvis, but may also occur in normal pelves.
2. Should it be present where there is a normal pelvis, be certain that there are no displacing fibroids or pelvic tumors.
3. The dangers are prolapse of the arm or the cord, or both.
4. In the primigravida a transverse lie of the fetus is considered to be almost always an indication for Cesarean section.
5. In the multigravida with a fair-sized infant and failure to progress, Cesarean section is indicated. Where the baby is small and the pelvis adequate, it may be possible, after the cervix is completely dilated, to guide the head over the inlet between contractions and allow the contractions to fix it there until the normal mechanisms of labor are able to facilitate delivery.
6. Where the arm has prolapsed (and provided dilatation is complete and the infant is not too large) the arm can be delicately replaced under deep relaxing type anesthesia, and version and extraction performed. It is unwise to allow long labor with an arm prolapse because great damage from ischemia can occur to the arm of the infant. Replacing the arm when the cervix is dilated only to the diameter of the arm usually results in a repeat prolapse. In such cases Cesarean section should be performed. The incision in the lower segment should always be a vertical one and not a transverse one. Otherwise, there will be great difficulty in extracting the infant.
7. Rupture of the uterus is not an uncommon experience in neglected cases of transverse lie of the fetus.
8. Diagnose these malpositions early! Be aware of the many possible complications and substitute abdominal delivery where the dangers of delivery from below might prove too hazardous.

Face and brow as the presenting part are rare and occur when the head is extended rather than the usual flexed attitude. The face presentations are in extreme extension, and the brow in partial extension; this interferes with the normal mechanisms of gradual descent and gradual extension of the head. In these problems a diameter of the head which is longer than that of a normal vertex, is attempting to accommodate itself to the various planes and diameters of the pelvis.

1. With a generous pelvis and a relatively small infant, spontaneous delivery may occur.
2. No attempt at correction should be done until complete dilatation has occurred.
3. Attempt at correction may be made by disengaging the head and flexing it, and then with subsequent labor contractions, aided by an assistant guiding the head in the new flexed position into the pelvis. In this maneuver, do not try to apply forceps to the head while it is floating, after correction to the flexed position.
4. If the face or brow has progressed to the perineum, it may be possible, with appropriate forceps maneuvers and a very generous episiotomy, to deliver it as such.
5. If the chin is posterior, it may be possible to apply the forceps and rotate to chin anterior, and then to reapply the forceps and with gentle traction and flexation to deliver over a generous episiotomy. This applies when the face or brow

Summary of a presentation at the Conference on Problems of the Newborn, St. Vincent's Hospital, Green Bay, Jan. 18, 1962.

Doctor Kilkenny is associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine.

is on the perineum. Manual rotation may be substituted for forceps rotation.

6. Where face or brow presentations constitute an obstructive type of labor, stimulation with oxytocics is contraindicated.
7. Force and high application of forceps are also contraindicated.
8. Version and extraction are not to be considered unless one can be certain that the pelvis will, with a degree of facility, permit the passage of the infant, and then only with deep relaxing type anesthesia.
9. If, in attempting delivery, it is found that it cannot be accomplished with the ordinary and accepted regards for the safety of mother and infant, it is far better to do an abdominal delivery than to persist in delivery from below in the face of great difficulty.

ROENTGEN RIDDLE . . . one of a series

HISTORY: An 18-year-old white woman, who was known to have a cardiac murmur since birth, complained of recent onset of dyspnea on exertion and easy fatiguability. There was no history of cyanosis and prior to her present illness she had been in excellent health. No history of rheumatic fever was obtained.

PHYSICAL EXAMINATION: The patient was well developed and the blood pressure was 120/80 in both arms. The palpation of the chest revealed the apical impulse to be in the left fourth interspace but the main precardial impulse was along the left sternal margin. There was a thrill parasternally on the left. A grade 4 to 5 harsh, prolonged, intense systolic murmur was present in the left second interspace parasternally and the second pulmonic sound was markedly diminished. Laboratory data was not unusual. An electrocardiogram was interpreted as abnormal on the basis of a right ventricular hypertrophy pattern.

X-RAY: The posteroanterior chest roentgenogram revealed a huge main pulmonary artery segment. The remainder of the cardiac silhouette was normal. The pulmonary vasculature appeared diminished and no parenchymal abnormalities were evident.

DISCUSSION on page 351

Prepared by A. M. Richter, M. D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M. D., radiologist, Department of Radiology at Milwaukee County Hospital.

Transfusions in Obstetrical Emergencies

By EDWARD A. BIRGE, M. D.
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FROM TIME TO TIME as obstetrical deaths are reviewed by the Maternal Mortality Committee, one finds a maternal death which appears to have resulted from a failure to use blood promptly. Such cases usually result from an obstetrical emergency or complication. In some small institutions the lack of a blood bank might account for the failure to act promptly. However, in some of the larger institutions the delay is less easily understood because adequate supplies of blood should be available.

In some instances the reason for the delay lies in the desire of the clinician and/or the laboratory to scientifically cross-match the blood. Research performed in the last 20 years has demonstrated the presence of an ever enlarging number of antigenic factors which can cause difficulty either at the time of transfusion or in later life. To exclude the common antibodies one uses a cross-matching procedure which requires a minimum of one hour after the blood is taken to the laboratory. When one allows for the delays of drawing blood from the patient and finding the technologist, if the emergency occurs outside of regular laboratory hours, one can readily see how a period of two or even three hours may elapse. A delay of this magnitude may cause a reversible shock to become irreversible, and blood, when it is finally available, no longer has the desired effect. In situations such as this, one should forego scientific cross-matching and utilize the blood which is available. If a sample of the patient's blood is available in the laboratory, and if the technologist is available, and if the cross-match procedure can be done promptly, a rapid saline cross-match designed to detect ABO incompatibilities can be done in approximately 5 minutes. However, if time must be lost obtaining blood from the patient, finding a technologist, or if the hemorrhage is truly tremendous, one should omit even this rapid cross-matching procedure. One should remember that for many years group O blood was used routinely to transfuse all blood groups with few serious reactions. Although we now know that the routine use of group O blood is not scientifically desirable, it can under certain circumstances be utilized as a life-saving measure. The Maternal Mortality Committee would, therefore, suggest that when a sudden emergency necessitates the prompt use of blood, the patient be given low titer group O blood, if it is available. If low titer group O blood is not available, any group O blood should be used.

The Rh type of the blood can be disregarded under these special circumstances since the Rh factor is a relatively poor antigen. However, if the patient is an Rh negative, Rh negative blood should be used if it is available. If the patient is Rh positive, Rh positive blood should be used. In either event, one should be more concerned with ABO compatibility.

If one is certain of the patient's blood group, then blood of the appropriate group may be used. Thus, group A blood would be used for Group A patients, Group B for Group B patients, etc. Such a procedure should only be done when the attending physicians are absolutely certain of the patient's blood group. If there is any doubt, group O blood, high or low titer, is to be preferred to the A or B groups.

The decision to utilize blood without cross-matching must be made by the obstetrician and must be based on the clinical circumstances. If the patient has lost massive amounts of blood in a short time, blood replacement should be done at once. Delay may well produce a state of irreversible shock. Plasma and saline infusions are poor substitutes for whole blood in cases of severe hemorrhage. If the blood group and type of the patient is not known, low titer group O, Rh negative blood is perhaps the best substitute. On a statistical basis, low titer, group O, Rh positive blood would be compatible with 85% of the white population. When life hangs in the balance, blood should not be

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Prepared at the request of the Maternal Mortality Study Committee of the State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments.

Doctor Birge is director of Laboratory, Milwaukee Hospital.

denied a patient because it is the wrong Rh type, or because of the possibility of future sensitization to the Rh factor. When the group and type of the patient are known, one should utilize the blood of the appropriate group and type, if available. If it is not available, then low titer group O blood should be used. In these emergency situations, one should always keep in mind the fact that it is much better to have a live patient treated somewhat unscientifically than a dead patient who has had all the benefits of modern science.

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ROENTGEN RIDDLE

continued from page 349

DISCUSSION: Pulmonary valvular stenosis was the suggested diagnosis. Congenital pulmonary valvular stenosis with intact interventricular septum, once considered a rare entity, is said to account for 10 to 14 per cent of all congenital cardiac lesions. A conclusive diagnosis is established at cardiac catheterization. The principal findings are an elevated right ventricular pressure and a normal pulmonary artery pressure. Normally the right ventricular pressure is about 20/0 and that of the main pulmonary artery 20/12. In severe cases of pulmonary valvular stenosis readings as high as 300 mm. Hg. have been recorded in the right ventricle at catheterization. Although the disease is most often congenital, an acquired form is sometimes present in patients with a malignant carcinoid syndrome. The circulating serotonin (5-hydroxytryptamine) is thought to produce a "chemical valvulitis" with resulting stenosis of the pulmonary valve.

Clinically, most patients are asymptomatic until the right ventricular output is greatly diminished. Only then do dyspnea on exertion, easy fatiguability and slight peripheral cyanosis appear. That this may not happen until well into adult life is established in case studies. An abnormal chest x-ray film or a cardiac murmur are the two common findings that usually initiate a more extensive cardiac examination. Main physical findings are those found in the present patient.

Radiographically the presence of a dilated main pulmonary artery is nonspecific. Generally speaking, prominent pulmonary vasculature represents a response of these vessels either to increased pulmonary blood flow (e.g. left to right cardiac shunts or hyperkinetic states such as hyperthyroidism) or increased pulmonary peripheral vascular resistance (e.g. primary or secondary pulmonary hypertension). Such is not the case in pulmonic valvular stenosis. Here the dilated main pulmonary artery is thought to be due to the turbulence of the blood jet just distal to the stenotic pulmonary valve orifice. The diagnosis is suggested on routine roentgen examination of the chest by failing to find associated lesions which might suggest another reason for the dilated main pulmonary artery. The decreased pulmonary vasculature is at times difficult to evaluate.

Evidence of right ventricular chamber enlargement such as the elevation of the apex of the heart and obliteration of the retrosternal space on the lateral projection may also be present.

The differential diagnosis roentgenographically, however, is not too difficult in view of the clinical findings. Unfortunately the prominent pulmonary artery is not seen in all cases. The finding is said to be positive 33 to 50 per cent of the time.

TREATMENT: In some instances the degree of stenosis may only slightly elevate the right ventricular chamber pressure. Cardiac surgeons generally agree to continued observation of these patients. If the stenosis is severe, the right ventricular output diminished, right ventricular strain patterns evident on electrocardiographic studies or the patient is symptomatic, corrective surgery should be done.

BEHAVIOR PATTERNS OF PREMATURE INFANTS

"Behavior Patterns of Premature Infants, A Nursing Study," by Eileen Hasselmeyer, R.N., was recently published by the Division of Nursing, U.S. Public Health Service. It represents the first known attempt in the United States to test the effect of a diaper roll support on the well-being of prematurely born infants.

Analysis of the data collected showed that the larger "preemies" do appear to sleep more, cry less, and move about less when provided with diaper roll support, but the support did not result in greater weight gain for premature infants.

The research was carried out in the premature unit of Bellevue Hospital Center in New York City. All 59 subjects weighed under 4½ pounds at birth. Thirty of them had a rolled diaper placed at lower back or side for support. The remaining 29 served as controls. Using measurement methods developed for this study, observers checked the infants every 10 minutes around the clock from 3 to 6 weeks and kept records of their sleeping, crying, moving, eating and other behavior patterns.

"Behavior Patterns of Premature Infants" (Public Health Service Publication No. 840) is available from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., at 50 cents a copy.

Diagnosis and Management of Fetal Distress in Labor

By JOHN R. EVRARD, M. D.
Milwaukee, Wisconsin

Points to remember in the diagnosis and management of fetal distress in labor are outlined below:

1. *Incidence*: 6% of all labors—240,000 labors in the United States each year show fetal distress.
2. *Definition*: Normal rate FHT is 120–160. FHT should return to normal within 30 seconds after contraction ceases. Sustained bradycardia below 100 is evidence of fetal distress.
3. *Signs and Symptoms*: Fetal tachycardia, fetal bradycardia and fetal arrhythmias; excessive fetal activity and passage of meconium with vertex presentation are not significant.
4. *Etiology*: Abnormalities of cord and placenta (cord complications: compression, prolapse, thrombosis; abruptio placenta; and placenta previa), dystocia (cephalopelvic disproportion; breech; difficult forceps), analgesia and anesthesia (maternal respiratory depression due to analgesics and anesthetics; hypotension associated with spinal), excessive uterine contractions (Pitocin stimulation; precipitate labor), toxemia and postmaturity (uterine blood flow reduced by ⅓), miscellaneous (Rh disease; congenital anomalies), unknown.
5. *Management*: Administer oxygen and dextrose. Diagnose obstetric complication (sterile vaginal; x-ray). Assess severity of distress (tachycardia: sustained, due to maternal hyperpyrexia; transitory, not significant unless preceded by bradycardia [hypoxia], sometimes due to mobile cord); bradycardia (normal bradycardia during contractions; should not persist longer than 30 seconds after contraction); arrhythmias (with normal rate not significant; with bradycardia this is evidence of severe distress).

Summary of a presentation at the Conference on Problems of the Newborn, St. Vincent's Hospital, Green Bay, Jan. 18, 1962.

Doctor Evrard is assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine.

LABORATORY NOTES No. 2 of a series

Biliary Obstruction

Obstruction to the discharge of bile may be intrahepatic or extrahepatic in origin. Only the conditions effecting extrahepatic obstruction will be considered at this time. The lesions which present as difficult diagnostic problems related to extrahepatic sites may be caused by calculi, cancer involving the head of the pancreas, the ampulla of Vater, gallbladder or bile ducts, adhesions, congenital atresia of the ducts, or pressure upon the ducts by some extrinsic tumor. There is no single laboratory test which will determine the type and site of obstructing lesion. However, the judicious selection of a number of tests can be of immense value in making the diagnosis.

Laboratory Findings

1. Total serum bilirubin is elevated.
2. One-minute direct bilirubin is elevated.
3. Serum alkaline phosphatase is increased.
4. Fecal urobilinogen is reduced. (In complete obstruction it is absent.)
5. Urine urobilinogen is reduced or absent.
6. Total cholesterol is increased.
7. Serum cholesterol esters are reduced when there is liver damage.
8. Bromsulphalein cannot be utilized in the presence of jaundice.
9. Serum total protein is normal unless severe liver damage results.
10. Serum mucoproteins are reduced in extrahepatic biliary obstruction.

The most valuable procedures of the above would be the total bilirubin with the one-minute direct included. If the one-minute direct bilirubin is over 0.28 mg. per 100 ml., it is probably abnormal. If it is above 0.33 mg. per 100 ml., it is definite evidence of biliary tract disease. This is a very valuable procedure in differentiating extrahepatic from intrahepatic jaundice.

Prepared by S. H. Holt, M.D., Director of Laboratories, Kenosha Hospital, Kenosha, Wisconsin.

The Performance Testing Program for Syphilis Serology in Wisconsin

By JOSEPH W. JOY, M. S.
Madison, Wisconsin

SYPHILIS SEROLOGY has long been an important tool in the differential diagnosis, detection, and treatment of syphilis. With the current upward trend in the number of cases of syphilis, reliable and reproducible serologic testing methods are essential. Coupled with this situation is the realization that there is an increasingly greater number of diseases or conditions which may result in a biologic false reaction, and that the extensive use of antibiotics has altered the serological picture in some cases.

If the laboratory is to continue to be an important factor in aiding the physician, it must keep pace with the newer methods for the control and the evaluation of serologic tests for syphilis. Various agencies, organizations, and societies are presently engaged in programs designed to improve laboratory testing.[1] Among these is the Venereal Disease Research Laboratory of the U.S.P.H.S. which for over twenty years has aided state laboratories in the development of sound serological procedures and the initiation of intrastate evaluation programs. [2-5]

In 1958, the Wisconsin State Board of Health began a voluntary study of performance testing for laboratories approved to do premarital blood testing. The State Laboratory of Hygiene acted as the administrative laboratory and the Venereal Disease Research Laboratory served as the reference laboratory in this program. During this period of voluntary participation, these services were made available: copies of *Serologic Tests for Syphilis;* periodic laboratory inspections; training on an individual or workshop basis; consultation services; suggested procedures for diagnostic problem cases; and serological unknowns for performance testing.

These unknowns (ten each month for ten months each year) were five split-specimens or five pairs of serums. With this type of unknown, test performances could be evaluated as to reproducibility and agreement. Reproducibility measures the laboratory's ability to obtain identical results on each of two identical serums; agreement is a direct comparison of the results reported by the participating laboratory with the results obtained by the reference laboratory.

A series of trial dilutions were prepared from reactive serum using nonreactive serum as the diluent. Those dilutions representing typical reactive, weakly reactive, and nonreactive serums were selected to give a combination of unknowns that would test the laboratory's performance in qualitative and quantitative serology. Larger pools of the selected dilutions were prepared, Merthiolate powder added, then filtered through bacteria-retaining Seitz pads, rechecked serologically, dispensed under aseptic conditions into sterile vials which were labeled with code numbers and mailed. The mailing and testing dates were determined in advance and all laboratories notified before shipment. Enclosed with each set of serums were instruction and report forms.

The serology section of the State Laboratory tested the unknowns on the designated date and forwarded the results to the reference laboratory. The reference laboratory, in turn, sent its findings to the State Laboratory. These results from the reference laboratory were then used as the basis for evaluating the performance of all participating laboratories, and copies of these results were mailed to them. Annually, a complete summary of the test performances was published, using code numbers to identify all laboratories except the reference laboratory and the State Laboratory.

As a result of this voluntary trial period, there has been general improvement in the testing done by all laboratories; but there has been far greater improvement among those laboratories that have participated the longest. Effective July 1, 1962, the program becomes mandatory for laboratories seeking approval and certification for doing syphilis

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serology. Past experience indicates a future overall increase in reliability and reproducibility in syphilis serology performed by approved laboratories in Wisconsin.

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INCREASED INCIDENCE OF INFECTIOUS SYPHILIS

The trend line of infectious syphilis reported in the United States continues to rise at an alarming rate. The 18,781 cases of infectious syphilis reported in fiscal year 1961 is the greatest number reported in any year since 1950. This figure represents a 50 per cent increase over 1960, and more than triples the number of infectious syphilis cases reported in 1957.

Not only is the total number of infectious syphilis cases increasing, but the number of states and cities reporting increases over previous years is also climbing steadily. In 1957, the number of states and cities reporting increases in early infectious syphilis was 20 and 25 respectively. In 1961, 40 states and 72 cities reported increases over the previous year. In other words, the syphilis attack rate is increasing sharply in four-fifths of the United States.

Morbidity data for the first six months of fiscal year 1962 indicate that reported infectious syphilis will continue a sharp rise throughout the present year.

There has been a consistent increase in the number of venereal disease cases reported among persons 19 years of age and under: 48,964 in 1957, 53,881 in 1958, 55,763 in 1959, and 61,265 in 1960. Infectious syphilis cases reported in the 15–19 year age group increased 59 per cent in 1960 over 1959. Infectious syphilis in the 20–24 year age group increased last year by 73 per cent. Twenty-five states and 36 cities reported increases in the 15–19 age group and 35 and 53 respectively, in the 20–24 age group.

Twenty-nine states and 31 cities reported venereal disease outbreaks during 1961. These explosive chains of infection occurred in all sections of the United States. Interstate transmission of syphilis was a factor in several outbreaks. Promiscuous teenagers were represented in most venereal disease epidemics. Preventive treatment, contact investigation, and cluster testing were the most effective techniques in bringing the outbreaks under control. —Excerpt from *Today's VD Control Program*, March, 1962.

CURRENT LITERATURE ON VENEREAL DISEASE

Since 1957, infectious syphilis has been increasing at an alarming rate in all races, sexes, ages, social groups, and geographic areas, according to a recent letter from William J. Brown, M.D., Chief of the Venereal Disease Branch, Department of Health, Education and Welfare. Doctor Brown added that physicians who have not observed a single case of infectious syphilis in 20 years suddenly are finding it among their patients.

Concurrent with this resurgence, unfortunately, is a paucity of venereal disease literature and information available to the private physician, Doctor Brown continued.

To partially alleviate this situation and serve a pressing need, the Venereal Disease Program of the Public Health Service routinely abstracts current articles on venereal diseases from almost 1,000 journals both domestic and foreign. A publication entitled "Current Literature on Venereal Disease" including these abstracts is printed three or four times a year and indexed annually, Doctor Brown indicated. It is distributed regularly free of charge to physicians on their personal request.

Requests should be directed to: Communicable Disease Center, Atlanta 22, Georgia, Attention: William J. Brown, M.D., indicating that the physician's name be added to the mailing key for "Current Literature on Venereal Disease."

CONTROL OF RADIATION EXPOSURE IN DIAGNOSTIC RADIOLOGY—A FILM

A new 16-mm sound film in color entitled "Radiation: Physician and Patient" is available without charge from the American College of Radiology, 20 North Wacker Drive, Chicago 6, Ill., the Wisconsin State Board of Health, or the AMA. The film, which runs 45 minutes, deals with medical aspects of radiological uses. The film is pertinent at this time when more emphasis is being placed on the role of radiation in American life.

Editors
H. F. HARDMAN, M. D., Marquette University
F. E. SHIDEMAN, M. D., University of Wisconsin

COMMENTS ON TREATMENT

Promising Developments in Penicillin Therapy

By F. E. SHIDEMAN, M. D.
Madison, Wisconsin

SINCE THE discovery and introduction of penicillin into clinical medicine, one of the problems constantly faced by physicians has been the possibility of the development of drug-resistant bacteria. This has been particularly bothersome in the case of *Staphylococcus aureus* and has given rise to serious problems in connection with infection by various strains of this organism. Fortunately, however, the picture is beginning to change as the result of developments within the past few years in the area of penicillin chemistry and biochemistry.

Whereas there appears to be a predominant underlying genetic mechanism for acquisition of drug resistance, there are undoubtedly many different biochemical and/or biophysical changes which may bring about the phenomenon. Although many experts in this area of research believe this to be the case, the mechanisms involved under clinical conditions with a given drug and organism may be relatively few in number. This appears to be true when resistance is acquired by the clinically important strains of *S. aureus*. Support for this concept derives from the work of English, McBride and Huang.[1] These investigators, aware of the existence in bacteria of at least two mechanisms for inactivation of penicillin, examined a series of penicillin-resistant organisms for their capacities to metabolically alter the drug by these two processes (Fig. 1).

Whereas three strains of penicillin-resistant *S. aureus* produced by laboratory methods did not contain penicillinase, all strains of resistant organisms isolated from patients contained the enzyme. Although no strains of *S. aureus* examined exhibited penicillin acylase activity, a number of other bacteria, e.g., *Escherichia coli*, resistant to penicillin were shown to exhibit this activity. These and similar observations have provided a basis for an attack on the problem of penicillin resistance by design of compounds refractory to enzymatic inactivation.

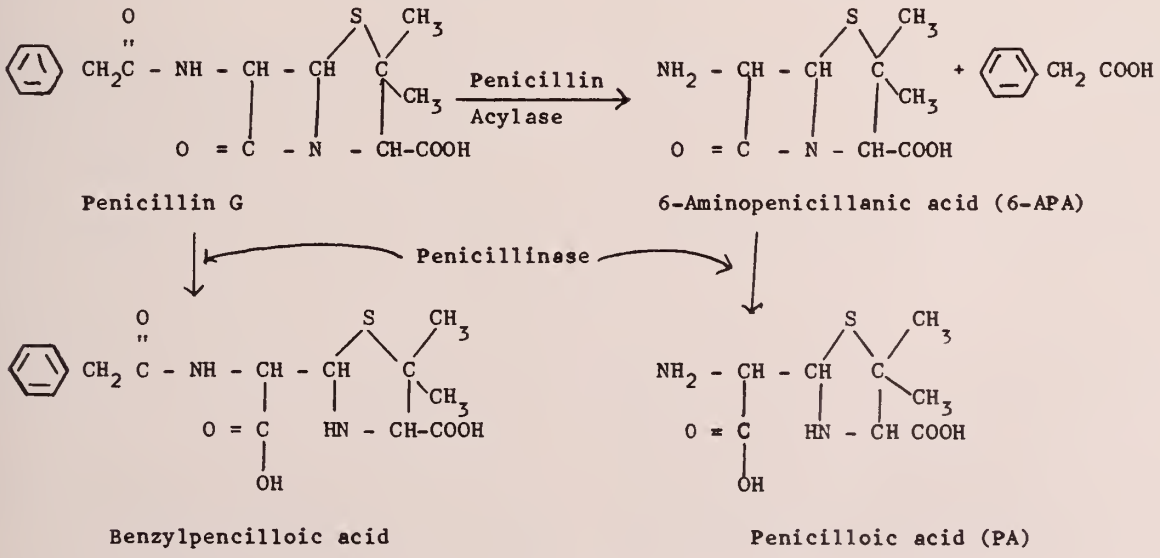
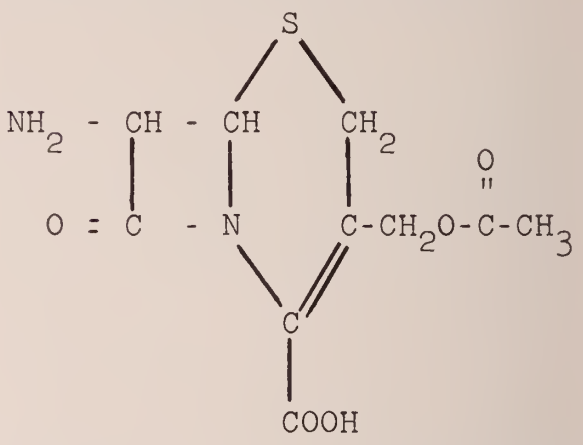


Figure 1

Prior to 1959 the number of different penicillins which could be produced was limited by the variety of structures which the penicillin-producing mold would accept for incorporation into the molecule, i.e. substituents on the amino group in the 6-position of 6-APA. The work of Batchelor et al.,[2] to an extent, has obviated this difficulty. They demonstrated that when *Penicillium chrysogenum* W 51.20 was grown in the absence of any compound which would attach to the amino group of 6-APA, accumulation of large amounts of 6-APA occurred in the culture medium. Thus, an inexpensive starting material was provided in large quantities for the production of innumerable "semisynthetic" penicillins.

Two such compounds which are resistant to inactivation by staphylococcic penicillinase already are on the market. They are methicillin (Staphcillin®, sodium dimethoxy penicillin) and sodium oxacillin (Prostaphlin®, sodium 5-methyl-3-phenyl-4-isoxazolyl penicillin). These penicillins are advocated for use only in the therapy of staphylococcic infections resistant to other penicillins. Methicillin is not resistant to acid inactivation and hence must be administered by injection. The recommended routes are intramuscular (deep intragluteal) or intravenous. It has been employed to advantage in a number of penicillin-resistant staphylococcic infections but should not be used in other infections since it is decidedly less active than the older penicillins. The usual adult dose is 1 gm. every 4 or 6 hours. Sodium oxacillin possesses an advantage over methicillin in that it is resistant to inactivation by acid and hence can be administered orally. The usual adult dose is 0.5 to 1 gm. administered every 4 or 6 hours. Dosage will be determined by the severity of the infection and the clinical response.

These, I am sure, are but the beginning of a variety of new compounds possessing the penicillin nucleus or a closely related structure which will ultimately be available for clinical use. Compounds eventually may be designed which not only are effective in the treatment of penicillin-resistant infections but also may have immunological properties so different from those of penicillin as to allow their safe use in penicillin-sensitive patients. A promising lead is the natural antibiotic, cephalosporin C. It is not acted upon by penicillinase but so closely resembles penicillin as to inhibit the enzyme in a competitive fashion as well as induce its formation by appropriate bacteria. The nucleus of this compound, 7-aminocephalosporanic acid (Fig. 2), is similar to that of 6-APA.



7-Aminocephalosporanic acid

Figure 2

One derivative, cephalosporin C_A, is many times more potent than cephalosporin C against *S. aureus*.[3]

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A NEW PENICILLIN DERIVATIVE RESISTANT TO PENICILLINASE, DIMETHOXYPHENYL PENICILLIN — A Reprint

Reprints of the Combined Clinical Staff Conference at the National Institutes of Health on A NEW PENICILLIN DERIVATIVE RESISTANT TO PENICILLINASE, DIMETHOXYPHENYL PENICILLIN, published in *Antibiotics & Chemotherapy* (Vol. XI, No. 9, September 1961), are now available to interested physicians upon request. Send request to: Clinical Center Information Office, National Institutes of Health, Bethesda 14, Md.

Report on Bicillin Prophylaxis Program

By PATRICIA McILLECE, M. D.
and
KATHERINE MAY, R. N.
Madison, Wisconsin

IT SEEMS appropriate at this time to report on the current status of the Bicillin prophylaxis program administered by the Bureau for Handicapped Children, since the revised policies will soon have been in effect one year.

The primary purpose of this program has always been to supply prophylactic medication at a reduced rate to those children with rheumatic fever or congenital heart disease whose families could not purchase it at the retail price. In order to carry out this purpose more effectively, certain policies were revised July 15, 1961. Since that date the Bureau has asked families to submit financial data in order to determine their eligibility to be included under this program. There is no rigid income level but rather each case is determined individually, on the basis of need.

The cooperation of the families has been excellent and to date only 13 families were considered as having too high an income to be included in this program.

The second major policy revision eliminated the need for confirmation of the diagnosis at a cardiac clinic. Physicians are asked to complete an application form which is based on the modified Jones Criteria.

It was also felt that a successful program should encourage close medical and nursing supervision of children with rheumatic fever and congenital heart disease. Therefore, the Bureau for Handicapped Children requests the family to contact its physician at six-month intervals. Follow-up forms are sent to the physician requesting information regarding the health status of the child and the present dosage of Bicillin. The Bureau attempts to follow up those cases where the physician indicates that the child has not been under medical care. In addition, each new child enrolled in the program is referred to the local public health nurse who in turn reports any pertinent information to the Bureau.

CURRENT STATUS OF BICILLIN PROPHYLAXIS PROGRAM FROM JULY 15, 1961, THROUGH JUNE 10, 1962:

Number of patients on program as of 7–15–61		1355
Number of patients removed from program	286	1069
Overage	59	
Moved out of state	17	
Expired	5	
Bicillin discontinued	53	
Purchased elsewhere	4	
Discontinued-economically too high	13	
Entered convent	2	
Had cardiac surgery (disc.)	4	
Congenital heart (disc.)	10	
Delinquent (this group did not respond to two letters sent to M.D. and family)	117	
Number of patients added to program since 7–15–61		422
Total number on program through 6–10–62		1491
Number of patients where family pay cost		1178
Number of patients where Bureau assumes cost		313
Follow-up reports from public health nurses		200
Application forms and educational material sent to physicians		315

We in the Bureau for Handicapped Children are most appreciative of the fine cooperation we have received from physicians and nurses throughout the state and are exceedingly proud of the warm response parents have given to our prophylaxis program.

THE PRESIDENT'S PAGE . . .

House Calls

THE PRESENT DAY controversial subject of house calls has become cause for concern among physicians. Some prefer not to make any, others a few; and still others maintain a regular calling list.

There are three places in which to see the patient—the hospital, the physician's office, and the home. Our problem is to see the whole person —the person, the environment, as well as the disease.

The hospital, with its extensive scientific equipment, is our best place to study the disease itself. In the last 50 years, hospitals have developed rapidly and dramatically. In the last two decades, nursing homes, convalescent homes, and homes for the aged have mushroomed. This latter group is still largely custodial in nature, but progress and evolution will change these into treatment centers. The diagnostic laboratory equipment, the new surgical techniques, and the recent therapeutic advances have made the hospital the place of choice for the study, diagnosis, and treatment of most medical as well as surgical conditions.

The physician's office has expanded from a waiting room and an examining room to a miniature diagnostic center. Laboratory facilities and trained personnel have improved the quality and efficiency of outpatient care. Many laboratory procedures are performed in the office that certainly cannot be done in the home.

Indeed, house calls have been "getting their lumps," in print and in practice because of the convenience, efficiency, and shorter working day made possible by hospital and office care. The family doctor of legend is remembered for his house calls, although we know he had an office and some hospital facilities. House calls still offer information, useful to the doctor and his patient, which is available nowhere else. No amount of lengthy, careful history taking or interviewing in hospitals or office can furnish the background information obtained from a visit in the home.

It is in the home, whether it be a room, an apartment, or a house with a family, that the patient must live with his disease. Here, he is seen in his own environment. Here, he talks freely about his hopes and fears, his ambitions and frustrations, without being afraid of being overheard or taking up too much time. The furnishings, the hobby equipment, books and magazines show what his work means and what his avocations may be. The voice and facial expressions tell what means the most to him. To know the

(continued on page 359)

When Your Patients Ask, "What is the AMA?"

Tell them that the American Medical Association:

—consists of 177,000 American doctors

—publishes the weekly JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, the world's leading medical periodical, the AMA NEWS; 10 monthly specialty journals; and numerous books, pamphlets and reports.

—provides timely information on such subjects as foods and nutrition, mental health, industrial health and rehabilitation.

—sponsors national meetings at which thousands of physicians exchange ideas and learn "what's newest" in research and medicine.

One-fifth of the AMA's annual budget is spent to inform the public through such means as TODAY'S HEALTH magazine, a question-and-answer service, TV and radio programs, films, exhibits and a research service for news media.

The causes for which the AMA works—and fights—are within its field of competence: medicine. They are always in the public interest. Even a partial list indicates their broad range:

—*Increasing the supply of physicians* by encouraging young people to undertake medical careers

—*Better distribution of medical services* through a physician placement bureau and an active program to help communities attract doctors

—*Better patient care* by working to maintain high hospital standards, and by encouraging the construction of nursing homes

—*Exposing quackery* and alerting the public to the dangers of food fads and unproven treatments

—*Promotion of voluntary health insurance*

—*Better medical care for the indigent* through cooperation with state and local governments

—*Sound legislation* to provide funds for hospital and medical school construction, improved pure food and drug laws, regulations for the control of hazardous substances, civil defense and medical stockpiling.

—Adapted from the PR section of MINNESOTA MEDICINE, 48:729, (Oct.) 1960.

THE PRESIDENT'S PAGE *(continued from page 358)*

state of one's health, to live with disabilities, and yet to retain as much as possible of the worthwhile interests from an earlier and healthier period, make the zest for living greater. All of this can be observed in a friendly as well as professional manner.

This valuable asset of the physician to observe, as well as to prescribe, offers a comprehensive way to obtain needed information about a patient. As activities become restricted or limited, it is necessary to seek other safe and reasonable outlets. The home will offer suggestions that may be overlooked in hospital or office. Where practicable, a visit to the patient's place of work may be of added help to the physician in his effort to keep incentives for the convalescent.

With due consideration of the value of the hosptial and the physician's office in the practice of medicine, the house call still remains an irreplaceable adjunct to the care and treatment of the patient.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

EDITOR'S NOTE:

Many physicians have become increasingly concerned by the fading public image of the doctor, but too few have done much about it other than to bemoan the injustice of it all. A refreshing exception is Dr. Walter C. Rattan, an obstetrician and gynecologist practicing in Kenosha. He has eschewed tired catch phrases in his indefatigable presentation of modern medical economics to service clubs, parents organizations and church groups, and each time his talk has produced a notable improvement in the attitude of his listeners toward the medical profession. In order to provide an example of a successful effort that could help all of us regain lost stature, Doctor Rattan was invited to transpose its essence to a guest editorial, and his excellent palimpsest follows.—D.N.G.

Facts Versus Illusions in Medical Economics — An Appeal to Logic

AMERICAN MEDICINE is probably without peer. People come from all over the world to attend our medical schools and train in our hospitals. New miracles appear so frequently that they are accepted almost as a matter of course. Frightful diseases which were commonplace a generation ago are almost unknown today. Far from being "ivory tower" progress, these advances have been delivered to the general public in such a way that the average child born today can expect to live 10 years longer than one born just 20 years ago.

In spite of all this, the public image of the doctor has suffered. The horse and buggy doctor of sentimental memory is revered beyond his just deserts, while the modern scientific model is publicly accused of being overly interested in economics, and not enough concerned with sociology.

What is the basis for this paradoxical situation? There is no question that most of it has to do with money. Let us examine some aspects of this problem. Part of the difficulty is as old as the profession itself: No one likes to pay for being sick. It's bad enough that an illness is unexpected, inconvenient, incapacitating, painful, and dangerous. That it should also be expensive is really too much of an injustice to bear. The result of this very human reaction is that practically no one budgeted money, on a realistic basis, for medical expenses. This one fact underlies to a great extent the vast structure of medical and hospital insurance that has

grown up in the last 20 years. This fact also makes the public susceptible to political promises that if the whole system were changed the pocketbook could be spared without sacrificing quality.

Another factor not generally considered is that treatment of an illness is one of the only facets of modern life in which no economic stratification occurs. If a poor man can't afford steak, he eats beans. If he can't afford a Cadillac, he can ride a bus. He can get along with a modest house, ordinary clothes, and very little recreation. But if this man is sick, he not only needs the very best but he needs it immediately; and, if anything, he needs it more than the rich man. A generation ago, if a man had certain diseases, nothing could help him. The cost therefore was likely to be small. Now, he probably can be cured. The cost might be $10.00 worth of medicine, or it might be six months' income. The latter is something new under the sun, and is responsible for many of the problems that have arisen.

Fortunately, we live in the kind of society where this man can get the care he needs. It may be paid for by some combination of public funds, private philanthropy, industrial planning, and individual forbearance on the part of doctor and hospital, but he gets it. There are probably very few exceptions to this statement. However, in the overall picture we cannot lose sight of the fact that this costs money—sometimes a lot of it.

What are the dimensions of the economic problems of good medical care? When viewed in perspective, they aren't as serious as one might think. Physicians' fees have gone up 90% in the last 20 years. At the same time, haircuts are up 218%, shoes 169%, food 151%, public transportation 139%, etc. Hospital costs, on the other hand, have increased more rapidly than almost any other item for which people spend their money. In spite of this, in 1961 Americans spent almost four times as much on recreation as on physicians' services, more for tobacco than for either hospital care or physicians' services, and almost as much for liquor as for doctors and hospitals combined. This does not suggest to the thoughtful observer that a major crisis exists.

Nevertheless, 6¢ of every consumer dollar is spent in one way or another on health (including drugs, appliances, etc.), and no one can deny that this is a sizeable item. Nor can anyone deny that a major, uninsured illness can be an economic disaster to the low or middle income family. Why is it so expensive?

It is expensive primarily because of the vast improvement in the quality of care, and this central, basic fact is inescapable.

Let us look first at the hospital side. A hospital building, first of all, is a very expensive item to construct. Second, the equipment that goes into a modern hospital is literally fantastic. The ordinary working laboratory of today's good hospital is better equipped than the finest research lab of 25 years ago. X-ray departments, surgical suites, physical therapy units—all must be expensively outfitted in order for the doctor to do the job of which he is now capable. Furthermore, economic feasibility of an item is not and cannot be a determining factor. If an item costs $5,000 and will save two lives a year, it will be bought. Third, hospital care is an industry in which very little automation is possible. In spite of a large amount of volunteer help, the average hospital has more than two employees per patient; and 70% of the operating budget goes for wages. In any ordinary community, the local hospital is one of its largest industries.

Next, let us look at the doctor's end of the picture. To make a physician of a high school graduate requires a superior person, eight years time, and $18,000 to $20,000 cash. One might add that despite these figures there isn't a medical school in the country that comes close to operating on income received from students. At the end of eight years, the new physician faces a year of internship; and due to the increasing complexity of modern medicine, there is more than an even chance that he will feel the need to specialize in a particular field. This requires an additional three to five years at little pay. Allowing two years for military service, the average physician entering practice is 29 years old, or if he specializes, 33. Not uncommonly, he is already several thousand dollars in debt. If the same individual had devoted the same talent and diligence to business or another profession upon finishing college, he would have spent about $12,000 less, and earned about $60,000 more. He faces a career which will require him to work an average of 62 hours a week, many of them in the middle of the night, so that he must plan to reduce his work load sometime around age 55 if he is to live as long as his contemporaries in other fields.

These sobering figures are some of the by-products of medical progress that ultimately must be faced, not just by doctors, but by the public. There exists a very real danger that in the next 20 years doctors will be in seriously short supply, and good ones will be even more scarce. In 1950, 22,000 persons applied for admission to the nation's medical schools. In 1960, there were 14,000. In 1950, 43% of all students accepted to medical schools had an A average in college; in 1960, this number fell to 15%. In 1940, there were 108 doctors in private practice per 100,000 population. In 1961, there were only 92, despite immigration of a large number of foreign graduates.

Three conclusions emerge clear and indisputable:

(1) There is not, and never can be, any such thing as good, cheap medical care, regardless of who pays for it—government, industry, insurance company, or individual. If it's good, it won't be cheap. If it's cheap, it won't be good. If this simple fact were made clear to the ordinary citizen, proposals for a change in the overall system of paying for medical care would receive more rational and less emotional consideration.

(2) Medical practice must continue to offer a considerable economic as well as idealistic attraction in order to entice the type of individual needed. Deterioration in the intellectual caliber of students accepted by medical schools must inevitably have serious consequences for the public at large.

(3) The *ultimate* success or failure of any new system of paying for good health care will be determined by a relative handful of talented youngsters who each year decide upon a career.

In the overall complex of medical economics, savings are possible, some of them substantial. Nothing in recent history suggests that this can ever be accomplished by the creation of yet another governmental colossus in Washington. Medical economics has become public business, as indeed it should be. Existing pressures for a fundamental change in the method of financing medical care arise from a *wish* on the part of some citizens that good health care could be bought more cheaply, and a *promise* by political opportunists that they can make the dream come true. The immediate decisions in this matter will be based on the public's conception of what is best for its health and its pocketbook.

In such a climate, the time has come when we as physicians must publicize the facts, and stop being content to deal in tired and often irrelevant clichés.—WALTER C. RATTAN, M.D., 6530 Sheridan Road, Kenosha, Wisconsin.

COMMENTS FROM THE PRESS

WAR ON QUACKERY

Six simple rules for spotting a quack were listed by the American Medical Association at Chicago Wednesday in connection with a national conference on medical quackery.

According to the A.M.A. department of investigation, you are probably dealing with a quack if he:

1. Uses a special or "secret" machine or formula he claims can cure disease. 2. Guarantees a quick cure. 3. Advertises or uses case histories to promote his cure. 4. Clamors constantly for medical investigation and recognition. 5. Claims medical men are persecuting him or are afraid of his competition. 6. Tells you that surgery or x-rays or drugs will cause more harm than good.

These rules should serve as a good guide for people who are ill and susceptible to one of the most despicable rackets known to mankind. People who are ill often develop a psychology that borders on the desperate. They will go to anyone they believe might cure them, which is the reason why Americans pay an estimated one billion dollars every year to these fake practitioners.

The financial loss is bad enough, but the precious time wasted by the patient while he is being treated by a quack is the most dangerous and cruelest part of it. In cases of malignancy such a waste of time is fatal.

The American Medical Association is rendering a great public service in its unceasing fight on these charlatans who think nothing of human life as long as they can reap their ill-gotton gains.—Reprinted from the *Sheboygan Press*, March 16, 1962.

THE MEDICAL FORUM

Petitions Bearing 57,000 Signatures Flown To Washington Opposing King–Anderson Bills

Petitions bearing signatures of more than 57,000 Wisconsin residents who oppose "further government control of medical care" were delivered June 22 to representatives and senators in Washington, D. C.

The petitions, circulated by members of the State Medical Society of Wisconsin and the Wisconsin Academy of General Practice, came from all parts of the state.

Dr. Nels A. Hill, Madison, president of the State Medical Society, commended the physicians of the state for making the petitions available to their patients.

"This is positive evidence that the people of Wisconsin want nothing to do with compulsory, government controlled medical care," he stated. "The King-Anderson bills, placing health care for some of the aged under Social Security, are just a first step in this direction."

"It must now be apparent even to Secretary of Health, Education and Welfare Ribicoff that the American people place a high value on the personal freedom for both patient and doctor which has brought this nation the finest health care in the world," Doctor Hill added.

The bundles of petitions, which weighed some 20 pounds, were presented to Dr. L. O. Simenstad, Osceola, delegate to the American Medical Association, who then flew them to Washington for presentation to senators and representatives.

The petitions are a part of an intensive effort by members of the State Medical Society in opposing government control of medicine.

The 57,000 signatures were obtained in a little less than a month. Additional petitions continue to arrive at the State Medical Society office; these will also be forwarded to Washington.

PETITIONS AGAINST KING–ANDERSON, more than 57,000 of them, were presented by Dr. Nels A. Hill, Madison, left, to Dr. L. O. Simenstad, Osceola, on June 22 at the Madison airport. Doctor Simenstad then flew the petitions to Washington, D. C., for presentation to Wisconsin congressmen. Said Doctor Hill, "This is positive evidence that the people of Wisconsin want nothing to do with compulsory, government controlled medical care."

COUNTY SOCIETIES GIVE TO STUDENT LOAN FUND

Two county medical societies have made recent contributions to the Charitable, Educational and Scientific Foundation. In May, the Clark County Medical Society contributed $25 to the student loan account. In June, Columbia-Marquette-Adams County Medical Society contributed $500 to the student loan account. These contributions have come at an appropriate time because the Foundation has some $14,500 in approved applications with virtually no money on hand to make the loans. The Foundation has made commitments of over $8,000 to medical students who are planning either to start or continue their education this fall. This money is needed by August.

Award Winning High School Science Exhibits, Sheboygan, at Museum of Medical Progress

Topping the nine prize winning Science Fair exhibits from Sheboygan area high schools on display during June at the Museum of Medical Progress at Prairie du Chien was one by John Shaefer, a senior at North High school in Sheboygan, which won for him a $4,000 scholarship from Marquette University. Placing fourth in nationwide competition, the young scientist also received a paid summer position with the Biological Laboratories of the U. S. Army Chemical Corps. His project, on a branch of cancer research, took him two years to complete and has won other cash and scholarship awards.

Other exhibits illustrated research and practical application of such subjects as hysterectomy on rats, artificial insemination in frogs, a complete exhibit on heat pumps, smoke tunnels and a student-made Van de Graaf generator, a "lightning" producing device.

NEWLY INSTALLED U. W. MEDICAL ALUMNI OFFICERS are Dr. Phillips T. Bland (left), Westby, president-elect, and Dr. Ben R. Lawton (right), Marshfield, president. They are shown with Dr. Albert Martin of Milwaukee, retiring president. Doctor Bland received his M.D. degree from the University of Wisconsin Medical School in 1947 and has been a physician and surgeon in Westby the past 10 years. Doctor Lawton is a 1946 graduate of the University of Wisconsin School of Medicine and is associated with the Marshfield Clinic.

State Health Board Specifies Use of Polio Vaccines

The State Board of Health has adopted the recommendations of the advisory committee on the use of polio vaccines which specify that Salk vaccine should be used until mid-October except in areas where an epidemic is impending. When one is impending, then live (oral) vaccine should be used as directed by local health authorities.

The advisory committee on polio vaccines includes: Charles K. Kincaid, M.D., Madison, Madison department of public health; Edward R. Krumbiegel, M.D., Milwaukee, Milwaukee city health department; Ruth Church, M.D., Waukesha, Waukesha county health department; J. R. Schroder, M.D., Janesville, Wisconsin Academy of Pediatrics; H. K. Tenney, III, M.D., Madison, University of Wisconsin Medical School; William E. Meisekothen, M.D., Madison, Wisconsin Academy of General Practice; Leon Gilman, D.O., Milwaukee, Wisconsin Association of Osteopathic Physicians and Surgeons; N. A. Hill, M.D., Madison, State Medical Society of Wisconsin; G. G. Shields, M.D., Wisconsin Rapids, district health officer, State Board of Health; Josef Preizler, M.D., and James L. Wardlaw, Jr., M.D., Madison, State Board of Health.

Recommendations Published

Recommendations for the participation of physicians in community polio-virus vaccine programs as adopted by the American Medical Association House of Delegates in June, 1961, appeared on page 278 of the May issue of the *Wisconsin Medical Journal.* Detailed recommendations of the State Board of Health appeared in the June issue on page 319.

NEUROLOGICAL CENTER CLOSES AT MADISON

On June 15 the Wisconsin Neurological Foundation at Madison finally closed its doors for lack of financial assistance. Closing of the hospital means the loss of a 60-bed facility valued at some $1.3 million to Madison as well as the loss of jobs to 78 full and part-time employes and a $230,000 annual payroll to the city.

The loss is even more significant to the patients of the neurological hospital and to the research workers who are now without facilities and help. When the hospital celebrated its tenth anniversary last year in May, approximately 750 persons from all sections of the United States had been patients at the hospital.

HOSPITAL WINS SAFETY AWARD

Washburn Hospital at Washburn was one of the winners with a perfect record in the 1961 Hospital Safety Contest sponsored by the American Hospital Association and the National Safety Council. Sixty-six contestants, operating over 31 million injury-free man hours, completed the contest with perfect records.

Winners Named in Annual Meeting Scientific Exhibits

Scientific exhibits at the annual meeting of the State Medical Society were divided into two classes and winners were judged as follows:

Lorger Hospitals and Universities

FIRST PLACE: *Radioactive Localization of Brain Tumors,* M. **Javid,** M.D., J. **Cameron,** Ph.D., and R. **Grant,** M.S., UNIVERSITY OF WISCONSIN MEDICAL SCHOOL.

SECOND PLACE: *Carotid Stenosis—Stroke Syndrome,* Drs. Harry P. **Maxwell,** Wayne J. **Boulanger,** James E. **Conley,** and Robert W. **Byrne,** COLUMBIA HOSPITAL, Milwaukee.

THIRD PLACE: *Fetal Electrocardiography,* Drs. Jack A. **Klieger** and Richard **Mattingly,** ST. JOSEPH'S HOSPITAL, Milwaukee, and the Department of Obstetrics and Gynecology, MARQUETTE UNIVERSITY SCHOOL OF MEDICINE; and S. D. **Larks,** Ph.D., Department of Bio-Physics, MARQUETTE UNIVERSITY SCHOOL OF ENGINEERING.

HONORABLE MENTION: *Lesions of the Central Nervous System,* WISCONSIN SOCIETY OF PATHOLOGISTS, in conjunction with the Department of Pathology, MARQUETTE UNIVERSITY SCHOOL OF MEDICINE.

Smaller Hospitals and Individuals

FIRST PLACE: *Case Presentations by Small Hospital Staff.* BEAVER DAM MEDICAL FORUM and BEAVER DAM HOSPITALS.

SECOND PLACE: *Treatment of Burns in a Private General Hospital,* Drs. George **Collentine,** John **Conway,** Burton **Waisbren,** and W. J. **Woloschek,** ST. MARY'S HOSPITAL, Milwaukee.

THIRD PLACE: *Maple Bark Disease,* Dr. Dean A. **Emanuel** and F. J. **Wenzel,** B.S., Marshfield Clinic Foundation for Medical Education and Research, MARSHFIELD CLINIC, Marshfield.

HONORABLE MENTION: *Block That Nerve,* Drs. Marvin **Wagner** and Sheldon **Burchman,** Department of Surgery, MT. SINAI HOSPITAL, Milwaukee.

COUNCIL APPOINTS DIVISION HEADS FOR STATE DEPARTMENTS

The Council of the State Medical Society has appointed 10 Wisconsin physicians to head the various divisions of the Commission on State Departments. Dr. T. W. Tormey, Jr., Madison, was reelected chairman of the commission and Dr. L. M. Simonson, Sheboygan, vice-chairman.

DIVISION ON AGING: Dr. A. M. Hutter, Fond du Lac

DIVISION ON CHEST DISEASES: Dr. H. A. Anderson, Stevens Point

DIVISION ON HANDICAPPED CHILDREN: Dr. J. W. Nellen, Green Bay

DIVISION ON MATERNAL AND CHILD WELFARE: Dr. John R. Evrard, Milwaukee

DIVISION ON NERVOUS AND MENTAL DISEASES: Dr. Keith M. Keane, Appleton

DIVISION ON PUBLIC ASSISTANCE: Dr. H. W. Carey, Lancaster

DIVISION ON REHABILITATION: Dr. Ray Piaskoski, Milwaukee

DIVISION ON SAFE TRANSPORTATION: Dr. Richard B. Windsor, Sheboygan

DIVISION ON SCHOOL HEALTH: Dr. L. M. Simonson, Sheboygan

DIVISION ON VISUAL AND HEARING DEFECTS: Dr. Meyer S. Fox, Milwaukee

Standing Committee Appointments Made

Appointments to standing committees of the State Medical Society for three-year terms are as follows:

Committee on Cancer

Dr. R. C. Frank, Eau Claire; Dr. G. I. Uhrich, La Crosse; Dr. R. C. Glise, Richland Center; Dr. G. A. Smiley, Delavan; Dr. J. J. Gramling, Jr., Milwaukee; and Dr. J. F. Brown, Rhinelander. Dr. Paul Cunningham, Appleton, a holdover member of the committee, was named chairman.

Committee on Grievances

Dr. E. D. Sorenson, Elkhorn, chairman; Dr. E. W. Mason, Milwaukee; and Dr. R. W. Mason, Marshfield.

Commission on Public Policy

Dr. R. G. Zach, Monroe, chairman; Dr. H. E. Oppert, Viroqua; and Dr. E. C. Quackenbush, Hartford. Dr. J. F. McIntosh, Madison, a holdover member, was named vice-chairman.

Commission on Scientific Medicine

Dr. John K. Curtis, Madison. The chairman will be selected at the next meeting of the Commission.

Commission on Hospital Relations and Medical Educotion

Dr. C. J. Picard, Superior; Dr. D. G. MacMillan, Barron; and Dr. W. E. Acheson, Valders. Dr. R. J. Botham, Madison, was appointed to fill an unexpired term of one year created by the resignation of Dr. G. M. Shinners, Green Bay. Dr. D. E. Dorchester, Sturgeon Bay, a current member, was named chairman.

SPAULDING ON HOSPITAL PANEL

James C. Spaulding, science editor of the *Milwaukee Journal,* will be one of three reporters interviewing two experts on hospitals and Blue Cross at the American Hospital Association's annual meeting Sept. 17–20 in Chicago.

HAVE YOU LOOKED AT YOUR INCOME PROTECTION LATELY?

Is your disability income insurance up-to-date?

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If the answer to any of the above questions is "yes", we suggest you contact your Time representative without delay.

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FOUNDATION TRUSTEES met for their annual report during the State Medical Society's annual meeting in Milwaukee May 7–10. Among items discussed was the announcement that plans had been made for a new exhibit hall to be constructed at the site of the Museum of Medical Progress at Prairie du Chien. The building will be a Butler-type, prefabricated steel structure with design and color to blend in with the present buildings. It will be 96 feet in length, 40 feet in width and 12 feet high. An overhang will cover the main entrance. The new building will honor Dr. William D. *Stovall*, president of the Foundation, and a prime instigator in the development of the Museum. The cost will be approximately $30,000. Contributions are being received now, and more are welcome, for financing this additional facility for properly exhibiting the history and progress of medicine. The Fort Crawford Military Hospital, which is housing all the exhibits now, can then be restored to its original setting in dramatizing the Beaumont experiments and the military medical history of Wisconsin. Plans call for completion of the building by mid August.

GOP Resolution Supports Kerr–Mills Legislation

The Republican Party of Wisconsin passed the following resolution at its state convention in Milwaukee late in May:

"WHEREAS, it is the function of government under traditional principles of American freedom to provide public assistance wherever need exists, while at the same time encouraging individual initiative and responsibility among those able to provide for the medical needs of themselves and their families; and

"WHEREAS, the Kennedy administration is attempting by all possible means and methods to foist upon the American people an additional regressive tax for compulsory medical care for the aged under Social Security; and

"WHEREAS, under this compulsory act large numbers of people who are financially able to care for themselves are nonetheless eligible for federal aid while other large numbers of legitimately needy people are not eligible for this aid; and

"WHEREAS, the Kerr-Mills bill, which has received an unsympathetic audience by the incumbent governor, provides for all needy people on a voluntary basis,

"Now, therefore, be it resolved that the Republican Party of Wisconsin, in convention assembled, does hereby go on record as supporting an approach to the problem of medical care of citizens in need of public assistance based on the traditional American principles as embodied and proposed in the Kerr-Mills bill."

Skill and Progress Raise Medical Costs

One of the reasons the cost of medical care has increased is because the quality of care has improved, Herman L. Toser, insurance director of the State Medical Society, told members of the Burlington Rotary Club recently. Medical costs can be frozen as soon as the public demands that skills and progress in medicine be stopped, he said.

Although medical costs have risen, they are not out of line with income, Toser stated. He pointed out that since 1939 the per capita income in the country has increased 289 per cent while medical care during the same period has increased 107 per cent.

WIN PRAISE FOR SCIENTIFIC EXHIBITS

A young Milwaukee physician and two Marquette University medical students won honorable mention recognition for their scientific exhibits at the Student American Medical Association's 12th annual convention held in Washington, D. C., in May. The Lakeside awards, presented annually to medical students and young physicians for their outstanding work in developing and presenting scientific information in exhibit form, went to Dr. David S. **Trump**, Michael J. Dunn and Jerome S. Fons. Lakeside Laboratories, Inc., Milwaukee, initiated the awards five years ago to stimulate interest in the use of scientific exhibits. The State Medical Society, through its Charitable, Educational and Scientific Foundation contributed $125 to help Mr. Fons with his exhibit expenses.

NEW NURSING BOOKLET

A new folder titled "Nursing Education Programs Today" has been issued by the National League for Nursing.

It contains information that will be useful to counselors and others advising young people about education in the field of nursing.

Copies are available from: National League for Nursing, 10 Columbus Circle, New York 19, N.Y.

Migrant Health Insurance Shows Gain

Since 1954, when the State Medical Society took the lead in setting up a special health insurance program for migrant workers, the Society has demonstrated that it can operate such a health care program at small cost to migrant workers and their families. Wisconsin Physicians Service, the doctor's plan of the State Medical Society, offers surgical-medical-hospital care insurance to migrant workers on a single or family basis. Dependents under the WPS contract include spouse and all unmarried children between 14 days and 19 years of age providing they are not working.

WPS 1962 weekly insurance rates for migrant workers are:

Single	$ .84
Family	2.31

Since 1959, when the WPS program covered 386 migrant worker employes, there was a slight increase in coverage to 486 in 1961. WPS expects the number of workers covered in 1962 to increase by almost one-third. Principal block to extending the coverage to a higher percentage of the migrant workers is the language barrier which must be overcome to achieve a common understanding of the purpose and need for health insurance.

Contacting the individual growers who employ nearly two-thirds of the migrant workers also has been difficult, but this may be simplified as a result of 1961 legislative action which now requires most farmers to register and carry workmen's compensation insurance for their employes.

Legislative Requirements

Any farmer who had 6 or more employes on 20 or more different days (not necessarily consecutive) in one calendar year must carry workmen's compensation insurance. —Chap. 387, 1961 Wisconsin Statutes.

At the peak of the 1961 season there were 381 state-licensed migrant worker camps containing 12,686 domestic migratory workers and 5,039 children under 16 years of age, 800 Mexican nationals and 294 British West Indies nationals.

The Mexican and BWI nationals were covered both by on-the-job workmen's compensation insurance and off-the-job health care insurance as part of the agreements with their governments.

Registration with WPS

Employers who want their migrant workers covered under a WPS contract ordinarily are required to register all of their migrant workers under the program. After the original registration, the list at the WPS home office is kept current simply by adding or removing names each week, when the employer sends in his report along with premiums deducted from migrant workers' earnings.

No identification cards are issued to individual workers. When a worker or member of his family requires care, the employer fills out and signs a printed form to be given to the doctor or hospital.

WPS policies for migrant workers include surgical-medical benefits for: (1) Up to $200 for surgical procedures. (2) Medical care in a hospital up to 30 days per illness. (3) Anesthesia and x-ray services associated with surgery. (4) Full payment within income limits for services covered by the contract if provided by participating physicians. No waiting periods are required.

Hospital expense benefits include: (1) Up to $10 a day for room, board and general nursing service for up to 120 days per admission. (2) Hospital charges for miscellaneous expenses necessary for treatment of injury or illness and for first visit care of injury or outpatient surgery. (3) Radiation therapy benefits.

Other Insurance Plan

Time Insurance Co. of Milwaukee, as a convenience to the 30 canning companies which participate in the Wisconsin Canners Association group health coverage plan for year-round employes, also offers migrant worker health care coverage, according to Marvin Verhulst, Madison, executive secretary of the canners association. The company does not offer the migrant worker coverage to other canners or growers, Verhulst said.

The Wisconsin Canners Association has supported and encouraged such health insurance plans. Each March, at its labor supply conference in Madison, the association invites WPS and Time Insurance Co. to explain their health care insurance plans to representatives of the canning companies.

STATE NURSING BOARD AWARDS SCHOLARSHIPS

The Wisconsin State Board of Nursing, at its annual meeting in June, awarded scholarships totaling $23,800 to 23 Wisconsin registered professional nurses for advanced preparation in public health and nursing education.

Dr. Addie M. Schwittay, Madison, was appointed to a three-year term on the Committee of Examiners for Trained Practical Nurses. Sister M. Jordan, R.N., director of Sacred Heart Hospital School of Practical Nursing, Milwaukee, and Mrs. Ethel Straw, T.P.N., Milwaukee, a staff nurse at Evangelical Deaconess Hospital, were reappointed to three-year terms.

Sister M. Regula, R.N., administrator of St. Francis Hospital, LaCrosse, was elected president of the Wisconsin State Board of Nursing. Miss Jeanette Welsch, Milwaukee, was elected vice-president.

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Dr. R. L. Rice New President Wisconsin Heart Association

Dr. Raymond L. Rice, Milwaukee internist and assistant clinical professor at the Marquette University School of Medicine, was installed as president of the Wisconsin Heart Association at its annual meeting in Madison in June. Doctor Rice, who has served on several committees of the Heart Association during his 10 years on the board of directors, is senior attending physician at Mount Sinai and Milwaukee County hospitals.

RAYMOND L. RICE, M.D.

CHARLES W. CRUMPTON, M.D.

Dr. Charles W. Crumpton, Madison, professor of medicine at the University of Wisconsin Medical School and director of the cardiovascular research laboratory at the university, was named president-elect. He also has served on the board of directors for the past 10 years.

MEDICAL ASSISTANTS ELECT NEW OFFICERS

Mrs. June Gillette, Sheboygan, has been elected president of the Wisconsin State Medical Assistants Society for 1962–63. Other officers are: Mrs. Marie Greismer, Racine, president-elect; Miss Shirley Kallas, Milwaukee, recording secretary; Mrs. Margaret Russell, Waukesha, corresponding secretary; and Mrs. Gwendolyn Selchert, Janesville, treasurer.

Members of the Commission on Public Relations and Communications of the State Medical Society met with the Board of Directors of WSMAS at the close of its convention held in Sturgeon Bay early in June. Commission members and Dr. W. J. Egan, president-elect of the State Medical Society, also attended the annual banquet and installation of officers.

ELIGIBILITY DATE IMPORTANT ON MEDICARE CLAIMS

Correct dating in Item 7 of the DA Form 1863–2, which is the current reporting form for Medicare claims (buff in color), is important in implementing prompt payment of services for which benefits are available. The proper date for this item, which calls for "Beginning Eligibility Date," is obtained from dependent's military I.D. card (Form 1173) where it appears in block 15B.

County Societies Invited to Sponsor AAPS Essay Contest

County medical societies and their auxiliaries are invited by the Association of American Physicians and Surgeons to sponsor a 1963 AAPS Essay Contest for High School Students in their area. Choice of topics for the 17th annual national essay contest is "The Advantages of Private Medical Care," or "The Advantages of the American Free Enterprise System over Communism." First prize will be $1,000, with a total of $2,675 to be given in national prizes.

Inquiries regarding the AAPS contest should be addressed to Dr. Thomas Parker, chairman, AAPS Essay Contest Committee, Suite 318, 185 N. Wabash, Chicago 1, Ill.

WPS ADDS NON-GROUP AGENTS

Addition of two more non-group agents who will sell Wisconsin Physicians Service coverage for individuals and families has been announced by A. H. Gardner, Madison, non-group agency supervisor.

The new agents are: Joseph W. Mueller, Burlington; and Kenneth V. Hendrickson, Argyle.

GUEST EDITORIAL

Seymour Press

MAY 10, 1962

As the Press Sees It . . . Don't Say We Didn't Warn You

The warning word from Washington is that the Administration-backed bill for medical care under Social Security now "has a good chance of passage" this session.

This is a bad dose of medicine for all of you men and women now at work—for your tax increase would be up to $25.25 each year.

Your money would be used to take care of those unable to pay their own bills—as well as those who are able to pay their obligations.

What the government do-gooders fail to point up is that more than half of those over 65 are already covered by their own health insurance policies—and this number is growing rapidly!!

Further, this bill comes up before the full effect of the Kerr-Mills Act has been felt. This is the legislation which takes care of the greater share of medical expenses, but only for those unable to pay.

President Kennedy's own figures forecast that the new bill would cost about $6 billion a year—all of which means further tax increases.

We suggest you relay this additional ammunition along to your representatives: No one has been able to prove that any large number of older people need medical care—or that they can't get it now.

FDA Curbs Huge Quackery Source in Milwaukee

With the sentencing of Royal Lee, president of the Vitamin Products Co., Milwaukee, the Food and Drug Administration by Federal Court action has stopped distribution of over 115 special dietary products promoted by false claims for treating more than 500 different diseases and conditions.

Federal Judge Robert *Tehan* sentenced Lee to a one-year suspended prison term with three years probation and fined the Vitamin Products Co. $7,000 on charges of interstate shipment of misbranded vitamins and proprietary remedies. Lee also consented to a permanent injunction covering Lee Foundation for Nutritional Research, Endocardiograph, Inc., and Leeland, Inc.

Lee holds a degree in dentistry, FDA said, but he has not been known to practice that profession. Instead he became one of the country's leading health faddists and a regular speaker on the subject. His 'health food' business is estimated at some $3,000,000 a year. Through nationwide distribution of literature by his Lee Foundation for Nutritional Research, Lee has incessantly attacked such well recognized public health measures as water fluoridation, milk pasteurization and vaccinations.

GUEST EDITORIAL

Is Medical Care Need Based on False Statistics

Waukesha Daily Freeman
MAY 3, 1962

Statistics can often become the most misleading of information. This is shown again in a comprehensive new defense department study which discloses that only 16 per cent of the young men turned down by the armed service is due to physical reasons. This refutes the widely held assumption, backed by statistical material, that American youths are physically weak and large numbers flunk routine examinations.

Declaring previous studies have been "grossly misleading and misinterpreted" the medical statistics division of the army surgeon general's office finds interpretations lumped all who failed to pass tests, even where the youths were rejected for mental and moral reasons.

There is reason to believe the same faulty approach is being made in presenting the problems of medical care to the nation. Pressure by government to win congressional adoption of the administration's King-Anderson bill is at its height. The nation's 17 million elderly citizens are pictured as an indigent minority group, sick and at the mercy of physicians and hospitals. This is the picture most often presented in arguments for the quick passage of a medical care program for senior citizens, tacked to social security.

In his meeting this week with representatives of the American Medical Association, President Kennedy insisted congress must adopt the costly plan because of the tremendous need, as shown in government statistics. Fortunately there is another side of our elderly population but it isn't mentioned by those who want federal care of the aged. It is both brighter and more realistic. Vast numbers of aged citizens are healthy and happy. In most cases they are integral parts of a family unit; not rejected, not unloved and not paupers.

* * *

According to a University of Michigan finding, large medical expenses tend to decline after age 54. More than half the aged are carrying some form of hospital insurance. Most of them are self-sufficient financially. Those who are not receive help when they need it. All are individualists, even though they are 65 and older, and they feel their importance and covet a desire to continue to be independent. We seriously doubt if the organization calling itself the National Council of Senior Citizens is speaking for the majority over 65 when it says of the administration's proposal "it is around the issue of medical care through social security that we unite for common effort."

This attempt to herd the aged under false pretenses is unfair to them and to their juniors. The elderly have a place in our society not unlike those who are much younger. It is within the great body of the American people, not on the outside looking in.

Deactivation of 32nd Spurs Medicare Benefits Inquiries

With the anticipated deactivation of the 32nd Division early in August, doctors and dependents of servicemen are requesting information as to termination of Medicare benefits upon discharge of the sponsor from active service.

Medicare benefits terminate at midnight on the date of the serviceman's discharge from active duty. This means that an eligible dependent receiving prenatal care may secure payment of charges incurred on or before the discharge date, but that Medicare *cannot* pay for the continued care and delivery which occurs *after* the discharge date.

Servicemen who had health insurance immediately before entry into active duty should check the possibility of continuous coverage credit toward contract waiting periods. Such credit will be given by some carriers if an application for reinstatement is made promptly upon discharge from service.

JACK HIGGINS WORKS WITH CHETEK DOCTORS

Jack Higgins, student at Indiana University Medical School, has been selected by the Student American Medical Association to work with Dr. Joseph E. Powell and Dr. Robert W. Adams in Chetek this summer. He is one of eight preceptors who will work two consecutive months in small communities which have successfully participated in the Sears-Roebuck Foundation's Medical Assistance Program. In addition to a $500 scholarship, each preceptor also receives free room and board in the community where he works.

Purpose of the program is to acquaint medical students with the elements of general practice work in small communities.

82,000 Attend Health Fair in Madison

Wisconsin State Journal Photo by John Kreissler

INITIATED PRINCIPALLY TO INFORM young people interested in careers in medicine or one of the allied fields of health, the Health Fair, sponsored by the Dane County Medical Society late in May, attracted 82,000 visitors. Many of them were classes of school children. Shown here are some of the lines waiting to get a close look at the popular "Life Begins" exhibit. A comprehensive report with pictures is tentatively planned for the September issue.

Physicians Wanted for Viet Nam

The U.S. State Department has asked the State Medical Society to assist in recruiting teams to staff hospitals in Viet Nam.

Each team would be made up of a basic nucleus of a surgeon, nurse anesthetist and operating room nurse. Also desired, but not essential, are a general practitioner, x-ray technician, and postoperative surgical nurse.

The State Department presently has 38 hospitals constructed in Viet Nam, 30 of them equipped with modern facilities for the hospital team.

Priority regions are in the delta area south of Saigon, the coastal area, and the western plateau area of the country.

Salaries for physicians start at $12,500 with an additional 25 per cent of the base salary for foreign service. Physicians with military commissions may transfer to the Public Health Service for the program; younger physicians who have not been in the armed forces may fulfill their military obligations, and those with no military connection can go as civil service employees.

Travel to Viet Nam is by first class air transportation for the physician and his family. Housing is provided. Length of the tour of duty is 24 months.

The program is operated through the Agency for International Development of the Department of State.

Physicians or other health personnel within the desired categories may obtain more information from: Mr. William Schaffrath, Health Branch FE, AID, 401—23rd St., N.W., Washington 25, D. C.

MID-SUMMER GOLF TOURNAMENT

The mid-summer WSMGA Tournament will be played at Oneida Country Club, Green Bay, on Monday, August 6.

ORAL POLIO VACCINE CLINIC PROVIDED AS PUBLIC SERVICE

Dr. G. R. Sandgren, Suring, organized and supervised the first oral polio vaccine clinic for the village of Suring and the surrounding area late in May. With vaccine purchased by the Suring Development Corporation, which is analagous to an association of commerce, and assisted by local registered nurses and volunteers and the two county public health nurses and their secretary, Doctor Sandgren offered the vaccine to anyone of any age, starting at three months, without charge.

Approximately 900 services were given between 10 a.m. and 12 a.m., according to Dr. G. M. Shinners, district health officer, and the services continued from 1 p.m. to 3 p.m.

"It was very worthwhile to see the high percentage of older persons, and I mean considerably above 50, passing through," reported Doctor Shinners.

KENOSHA COUNTY PLANS MASS PROGRAM WITH ORAL POLIO VACCINE

In a drive to eliminate the disease entirely, the Kenosha County Medical Society is planning a mass polio immunization program using oral vaccine in the fall. Until the oral program is completed, however, everyone is urged to continue his protection with the Salk vaccine.

Dr. R. G. Welsch and Dr. Morris Siegel of Kenosha have been placed in charge of the mass program. The cooperation of the Kenosha Health Department has been assured by Dr. Margaret Hatfield.

DR. BAKER WINS WSMGA TROPHY

Dr. Durward Baker, Milwaukee, after flipping a coin with Dr. John Garen, Jr., Kenosha, with whom he scored a tie of 77, won the first low gross trophy at the annual spring tournament of the Wisconsin State Medical Golf Association at Tuckaway Country Club May 7. Dr. C. L. Budny, Milwaukee, retained the senior event traveling trophy with a 79 and Dr. M. M. Aquino, Milwaukee, took the first low net trophy with an 88–28–60.

Minutes of Annual Council Meeting

Madison, February 24–25, 1962

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 1:50 p.m. on Saturday, February 24, 1962, at Society headquarters in Madison.

All voting members of the Council were present, Dr. W. J. Houghton on Saturday afternoon only, and Dr. E. J. Nordby present except Saturday evening. Officers and others in attendance were President Lokvam, Treasurer Weston, Speaker Callan, Vice-Speaker Carey, Doctors Quisling, Sullivan, Hildebrand and Stovall; Drs. J. S. Wier and Karl Siebecker for special orders Saturday afternoon; Mr. Charles Johnson of AMA field staff, Saturday afternoon. Staff and consultants present were Messrs. Crownhart, Thayer, Ragatz, Hansen, Toser, Murphy, Gill, White; Mmes. May and Anderson, Miss Pyre.

2. Approval of Minutes

The Minutes of the November and December, 1961, meetings were approved as distributed, for publication in the *Wisconsin Medical Journal*, on motion of Doctors Blanchard-Kief, carried.

3. Report of Planning Committee

a. Medical education efforts

Doctor Frank gave an informal report of certain efforts of the committee in the area of medical education.

b. Public health "listening posts"

On motion of Doctors Nordby-Bell, carried, the Council approved the pilot effort recommended by the committee, to be initiated in Eau Claire, of encouraging interested citizens to work directly with physicians through conferences on the adequacy of health care in the area.

On inquiry, Doctor Frank indicated it would be at least a year before the Committee could report back to the Council.

c. Meeting of special society representatives

On motion of Doctors James-Sorenson, carried, the Council approved the recommendation of the Planning Committee that a meeting of officers of special societies be combined with the caucus of section delegates for the purpose of information as to Society affairs and their role therein.

d. Bylaw amendment

On motion of Doctors Frank-Curran, carried, the Council forwarded to the House of Delegates an amendment to Chapter XI of the Bylaws on out-of-state membership transfers, as follows:

Delete in its entirety the fourth paragraph, Section 3, Chapter XI, of the Bylaws, which reads:

> "A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed."

Add a new second paragraph to Section 6 of Chapter XI to read:

> "When a member in good standing in a component society removes his principal practice outside the borders of this state, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this state shall cease upon his acceptance by a society in the new area of practice and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice."

Doctor Kief asked the status of several matters referred to the Planning Committee by the Council, namely, relations with osteopaths, AMA recommendations on medical discipline, and the proposal of holding two meetings of the House of Delegates. Doctor Frank answered that these matters have been under discussion by the committee, but it was not yet ready to make recommendations for Council action.

4. Medical Self-Help Training Programs

J. S. Wier, M.D., Fond du Lac, Chairman of the Council Committee on Disaster Medical Care, appeared before the Council to request official endorsement of a program urged upon state and county medical societies of supporting medical self-help training programs aimed at preparing one member in each family to take care of its health needs in event physicians are unavailable during a national emergency. Physicians are asked to provide guidance to the program and to volunteer their services as instructors for the courses in cooperation with the State Bureau of Civil Defense and the State Board of Health.

On motion of Doctors Dessloch-Kief, carried, the Council endorsed the program as presented.

5. Report of Committee on Economic Medicine

Doctor Egan, chairman, reported that the committee had no report except to inquire whether the Council wished his committee to study into the subject of the effects of economic conditions on the health of the people of Wisconsin.

Doctors Ekblad-Curran moved that the committee pursue the study.

6. Report of Committee on Scientific Medicine

Doctor Bell, chairman, reported as follows on items discussed at its meeting held Saturday morning, February 24:

a. House of Delegates meetings

Consideration was directed to a recommendation of the Commission on Scientific Medicine that in connection with the 1962 Annual Meeting, sessions of the House of Delegates and Reference Committee hearings be scheduled at

the Auditorium rather than at the Hotel Schroeder. Members of the Scientific Committee recommend that this plan be initiated in 1962, and then evaluated to see if it should be continued in 1963.

It has been noted that the Planning Committee of the Council is considering the possibility of scheduling the House of Delegates' principal meeting in the Fall, rather than in May during the scientific sessions. The Scientific Committee urged that this subject be prepared and presented to the 1962 House of Delegates so that an expression by the delegates can be secured as the basis for future planning. Doctor Bell felt this must be explained and recommended to the delegates, that a short meeting be held during the Annual Meeting to receive reports, and the general business meeting be held in the Fall.

On motion of Doctors Egan-Kief, carried, the recommendations were approved.

b. Dean's Page in *Wisconsin Medical Journal*

The Scientific Committee recommended that the *Wisconsin Medical Journal* invite the Deans at Marquette University School of Medicine and the University of Wisconsin Medical School to provide copy on an alternate, monthly basis, under the heading "The Dean's Page," to keep the profession informed as to new developments and programs taking place at the two medical schools.

On motion of Doctors Bell-Dessloch, carried, the recommendation was approved.

c. Podiatry

Doctor Bell asked Mr. Murphy to review the efforts of podiatrists in Wisconsin to secure inclusion of their services in Wisconsin Physicians Service contracts by rule of the Commissioner of Insurance.

On motion of Doctors Bell-Dessloch, carried, the Council approved the presentation to the Insurance Commissioner as contained in the following text of a letter to him by Secretary Crownhart, dated March 6, 1962, which summarizes the position of the State Medical Society (accompanying materials omitted):

"At the informal conference with you and members of your staff on February 7, 1962, I pointed out that some of the questions raised in connection with the treatment of podiatry and podiatrists under Wisconsin Physicians Service contracts involve public health questions as well as purely insurance questions, and that within the State Medical Society these are matters of general policy rather than decisions of Wisconsin Physicians Service, which is an insurance division of the Society and not an independent entity.

"On the same occasion I suggested that in light of issues raised by the Commissioner's inquiries, and because of misunderstandings which could result from a reading of the memorandum from the Wisconsin State Podiatry Society to you dated January 24, 1962, and the statement of policy from the same organization dated October 24, 1960, it might be more appropriate to limit the initial presentation by the State Medical Society to factual statements of the relationship of podiatry to the total health care of the public. The filing of such a statement was designed to furnish background for the assistance of your department and to clarify the position of the State Medical Society with reference to that background.

"We are recently in receipt of a study published in July, 1961, entitled 'Podiatry Education in the 1960's.' It is the Report of the Special Commission on Status of Podiatry Education, composed of five men, one of whom occupies a prominent position in teaching and administration at the University of Wisconsin, I. L. Baldwin, Ph.D. The Report was published by the American Podiatry Association. A copy is submitted for your study because it is up to date, it represents an apparently objective effort to evaluate current podiatry education and because it largely speaks for itself.

"We invite your attention in particular to the following pages of the enclosed Report:

Page 5 on the identification of the members of the Commission;
Pages 6–7. The first states that there are approximately 7,600 presently practicing podiatry in the United States; page 7 identifies and gives locations of the five colleges of podiatry currently in operation;
Page 15 on the geographical distribution of podiatrists. See also Table 1, p. 47;
Page 17, final two paragraphs, on physical plants, laboratories and libraries. See also p. 18, first two paragraphs;
Pages 19–20 on more extended discussion of library facilities;
Page 24, paragraph one, on academic qualifications of students;
Pages 27–29 enumeration of basic school resources and extent to which they remain unachieved;
Page 32 on limited podiatry research;
Pages 38–40 on the external relations of podiatry education;
Pages 41–42 noting that none of the colleges of podiatry is currently operated as a division of a university or closely affiliated with one;
Pages 43–44 which contain the conclusions of the Commission;
Page 47 showing distribution of podiatrists in selected states;
Page 49, Table 3, showing the capacity of the U. S. podiatry colleges in 1961 and the attendance in each.

"Enclosed with this letter is material identified as Part I. Its purpose is to supplement the enclosed Report.

"Also enclosed is material identified as Part II which contains a discussion of those legal questions which I think should not be deferred.

"My statement to you on February 7 emphasized that the presentation of the enclosed material was to be without prejudice to an opportunity by Wisconsin Physicians Service to file at an appropriate later time a more detailed treatment of some of the legal questions posed either by the Podiatry Society or members of your staff.

"In summary the State Medical Society's position is that:

1. Podiatrists are recognized ancillary technicians in the health "team."
2. Their training and license has been and remains quite limited.
3. Their numbers are limited and they tend, in Wisconsin, as elsewhere, to concentrate in the larger communities.
4. The future of podiatry is in substantial doubt, as is indicated by the enclosed Report. This uncertainty is aided by rapid scientific advances in the care of many conditions of the feet such as new forms of radiation and drug therapy.
5. Insurance is designed to meet unpredictable and often substantial health care costs. Typically the element of contingency is not present where podiatric services are performed, nor are the services normally emergency or catastrophic in nature. It is doubted that health insurance programs were designed to cover situations which are usually elective.

6. Wisconsin laws do not require that sickness care plans developed by the State Medical Society include benefits for services of podiatrists.
7. Inclusion of and rates for such benefits in areas where services are unavailable, as a practical matter, would tend to inflate costs of the program.
8. The fact that a podiatrist may perform a part of a service rendered by a physician does not discriminate in that the physician renders the total of patient care.
9. Some of the contracts now administered but not issued by the State Medical Society include benefits for services rendered by podiatrists. Where the need can be shown, the State Medical Society will undoubtedly extend such benefits to other of its contracts, on a *voluntary* basis, however.
10. The State Medical Society of Wisconsin may wish to require that such services be prescribed by a physician.

"This letter and accompanying exhibits has been reviewed by officers of the Society and by its Council (Board of Directors) so composed as to represent thirteen districts of the state.

"Please be assured of our willingness to elaborate in any respect desired by you and of our appreciation of this opportunity to present the views of the medical profession.

"This letter has been delayed more than a week during which we hoped to receive one or more additional copies of the report published by the American Podiatry Association. So as to permit your office to consider this matter without further delay, we enclose our only copy with the understanding that if we can't get another, we may wish to 'borrow' it back from you."

d. Policy on commercial exhibits

Eli Lilly had proposed to make a donation to the 1963 Annual Meeting instead of renting an exhibit booth. Because the withdrawal of exhibit participation by such a large pharmaceutical house might well tend to lead to disintegration of the Annual Meeting exhibit program, the committee recommended that this proposed donation be refused, that the company be urged to continue with an exhibit, and that Eli Lilly be contacted by the Foundation for additional support to postgraduate teaching programs in Wisconsin.

On motion of Doctors Bell-Kief, carried, the recommendation was approved.

e. Hospital accreditation symposia

The AMA has suggested that all state medical societies "incorporate a symposium on hospital accreditation in their annual meeting programs." The Commission on Scientific Medicine has recommended that if this be done, it be scheduled as an evening meeting and not directly associated with the scientific program.

The Scientific Committee of the Council recommended that this subject be made a part of the annual meeting of presidents and secretaries rather than as a part of the Annual Meeting.

On motion of Doctor Bell, seconded and carried, the recommendation was approved.

f. Wisconsin Elks health project

The Elks organization in Wisconsin has indicated a desire to support an approved health project of the State Medical Society. A proposal by the Wisconsin Association on Mental Health will be transmitted to the Elks organization with the suggestion that a national representative, as well as Dr. H. Kent Tenney representing the Wisconsin Association on Mental Health, be invited to meet with the Scientific Committee of the Council at the time of the Annual Meeting so that it can be discussed in greater detail, after which the Scientific Committee will be prepared to make appropriate recommendations to the Council.

On motion of Doctors Egan-Nordby, carried, this report was accepted.

g. Association of American Physicians and Surgeons

This organization had requested exhibit space at the Annual Meeting, and since it is not a scientific exhibit, cannot be included with those displays. It was recommended that space in the area outside of the hall where the House of Delegates will meet be provided, but at the same time efforts be made to secure an exhibit on AMPAC and housed in the same general area.

On motion of Doctors Bell-Egan, carried, the recommendation was approved.

On inquiry, Mr. Crownhart said that the State Medical Society has never taken an official position with respect to the Association of American Physicians and Surgeons which is currently conducting a membership drive.

7. Closed Chest Cardiac Massage

Dr. Karl Siebecker, Madison, showed a film and gave a demonstration of this technique, and an explanation of its use for certain emergency situations; the plan being to train police, fire, rescue, first aid and similar units in its fundamentals.

On motion of Doctors Van Hecke-Blanchard, carried, the Council endorsed the program of conducting professional training programs in the immediate future.

On further motion of Doctors Frank-Houghton, carried, the Council approved a program of making the means available to counties to conduct educational programs with non-medical groups.

8. AMA Field Service Activities in Wisconsin

At the request of the Executive Committee, Mr. Charles Johnson spoke to the Council on this subject, and urged active participation at the county level and through the Woman's Auxiliary in the legislation program.

The Council then recessed for dinner at 5:45 p.m. and reconvened at 7:35 p.m.

9. Report of Executive Committee

a. Committee on Utilization

On motion of Doctors Egan-Dessloch, carried, the Council approved the recommendation of the committee that the Chairman of the Council appoint a special committee to review studies referred to it by the Utilization Committee of the Commission on Medical Care Plans in the area of utilization of all forms of voluntary insurance.

b. Bylaw amendment

On motion of Doctors James-Willson, carried, the Council approved the following bylaw amendment to Chapter VII, Section 1, as recommended by the committee for presentation to the House of Delegates:

"The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the an-

nual report of the standing committee of which he is a member."

During the Sunday morning session of the Council, on motion of Doctors Bell-Egan, carried, action was taken that the chairman or a designated member of Council committees be requested to appear before the appropriate reference committee of the House.

c. Personal Service Corporation Law

On motion of Doctors Ekblad-Bell, carried, the Council approved the recommendation of the Executive Committee that Mr. Robert Murphy, the Society's general counsel, be authorized to act as amicus curiae in any suit involving a medical service corporation under this new law, or in any Internal Revenue Service interpretation or involvement in such corporation.

d. Wisconsin Week of Health

On motion of Doctors Curran-Blanchard, carried, the committee recommendation was approved that at an appropriate time this be developed as an occasion to bring to the attention of the public all that medicine is doing for and in the state. County medical societies and other organizations in the health field would be asked to cooperate with the State Medical Society in holding health fairs, career days, etc.

e. WMJ Advertising

In light of the declining advertising revenue over the past several years, the committee recommended Council approval to the solicitation of advertising for the Journal within the state through agencies, on a commission basis. The recommendation was approved on motion of Doctors Dessloch-Curran, carried.

f. Creation of new Council seats—Bylaw amendment

It was reported that there numbered sufficient members in the third and sixth districts at the end of 1961 to qualify them for an additional councilor, and the committee had discussed the apparent wish of the sixth district to seat its nominee immediately, at this meeting of the Council, on election by the Council. The committee reported its general consensus that (except in the case of a vacancy in an existing Council seat by reason of death or other cause) an actual vacancy should not be considered to exist until there is certification to the House of Delegates that a district qualifies for an additional councilor, and that this be done at the Annual Meeting through the normal process. To clarify the matter, it recommended the following bylaw amendment for presentation to the House of Delegates in May of 1962:

Add the following to Chapter VI, Section 7:

"When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the Councilors each year, as provided in Section 2 of said Article IX."

Doctors Bell-Dessloch moved that the proposed amendment be transmitted to the House.

Doctors Willson-Curran offered an amendment that the existing Chapter VI, Section 7, also be amended as follows:

"The Council *may*, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified."

The motion carried as amended.

g. Administrative rules of state agencies

The Executive Committee recommended study by an appropriate committee of the entire matter of the rule-making authority of state boards in matters of public health interest.

The chairman referred the study to the Commission on State Departments.

h. WMJ Advertising Policy

On motion of Doctors Willson-Ekblad, carried, the Council adopted the following rule recommended for incorporation in the Journal policy manual:

"The Journal will not run any advertising of a local concern which is not acceptable to the county medical society of the county in which the advertiser is located."

i. Presidential Citation

On motion of Doctors Egan-Bell, carried, the Council voted unanimous approval to the person nominated by President Lokvam to receive the citation in 1962.

j. Easement to SMS Realty Corporation

On motion of Doctors James-Egan, carried, the Council approved the recommendation that an easement over Society property be granted to the SMS Realty Corporation to validate construction and use of a connecting drive from the parking lot to the top of Edgewater Court.

10. Report on Implementation of Actions of the House of Delegates

The Council has asked for an annual report on the status of implementation of actions by the House of Delegates. Mr. Thayer presented an up-dating of the report made late in 1960 of actions since 1956, showing a total of 235 items with the addition of 1961 actions.

A number of the matters reported were discussed by the Council, but formal action was taken only with respect to chiropractic use of the title "doctor," as follows:

On motion of Doctors Curran-Frank, carried, the Council authorized inquiry of the State Board of Medical Examiners as to why it has not enforced Section 147.14 with reference to the use of the title "doctor" by those unauthorized to do so.

At the completion of this review of actions, the Council recessed at 9:55 p.m., reconvened at 9:40 a.m. on Sunday, February 25, as members of the SMS Realty Corporation, and resumed the business of the Council at 10:35 a.m.

11. Report of Finance Committee on the 1962 Society Budget

1961 operations: There was an actual loss, as predicted by the Secretary last May, of approximately $7,000, although the budget itself was underexpended.

1962 budget: This was reviewed in detail, and approved by the Council as presented on motion of

Doctors Dessloch-Ekblad, carried. Its major components are summarized as follows:

Dues—Membership and Supporting	$ 1,455
Conference Expense—Council and committee meetings; officers' travel, etc.	26,000
Promotion	5,050
Depreciation	3,200
Grants and Appropriations	2,700
Insurance—General	2,700
Miscellaneous Expense	2,500
Office Supplies and Expense	5,000
Outside Services	7,750
Postage	12,000
Printing and Forms—including publication expense of WMJ	61,700
Rent—Office	23,740
Rent—Other	7,000
Rental—Other Equipment	750
Repairs and Maintenance of Equipment	1,000
Resource Material	975
Speakers' Honoraria	2,300
Property Tax—Personal Property	350
Telephone	3,400
Accounting Services	4,000
Legal Services	5,700
Legislative Retainer	8,900
Subtotal, Operating Budget Totals	$188,170
Subtotal, Operating Budget Totals carried forward	$188,170
Staff Travel Expense	7,150
Payroll	128,048
Related Payroll Expenses	12,805
Total SMS Budget, 1962	
—Normal Provisions	$336,173
—Special Budgetary Provisions	20,000
—Field Service	39,100
	$395,273
Total Anticipated Income, exclusive of special assessment	$396,625

Special budgetary provisions include the mailing on a complimentary basis of *AMA News* and *Today's Health* to a group of some 2,000 civic leaders in Wisconsin, supplemented by occasional mailings of special material in fields of medical-economic interest. The field service has been budgeted on a full-year basis, although not anticipated to be completely staffed and implemented in 1962. No changes were recommended in executive salaries, which will be reviewed at the July meeting.

12. Election of Officers

On separate motion duly made, seconded and carried, Society officers were unanimously elected as follows:

a. Chairman of the Council: James C. Fox, M.D., La Crosse
b. Vice-Chairman of the Council: John M. Bell, M.D., Marinette
c. Treasurer of the Society: F. L. Weston, M.D., Madison
d. Assistant treasurers: H. Kent Tenney, M.D., John T. Sprague, M.D., and E. J. Nordby, M.D., all of Madison.
e. Secretary of the Society and of the Council: Mr. C. H. Crownhart, Madison
f. Editorial Director of the *Wisconsin Medical Journal:* D. N. Goldstein, M.D., Kenosha
g. Medical Editor of the *Wisconsin Medical Journal:* Victor S. Falk, Jr., M.D., Edgerton, two-year term.
h. Consulting Editor: R. S. Baldwin, M.D., Marshfield, two-year term.

13. Reports of Council Committees to House of Delegates

On motion of Doctors Curran-Nordby, carried, the Council authorized its Executive Committee to clear these reports as it sees fit.

14. Statement of Policy on Conflict of Interest

On motion of Doctors Blanchard-Nordby, carried, the following statement and certificate form, which are self-explanatory, were approved. Doctors Willson and Egan asked to be recorded as voting "no," although Doctor Willson said that didn't mean he would not sign the certificate.

"*Resolved*, That the Council hereby adopts the following formal Statement of Policy on Conflict of Interest, for application to all councilors, officers, members of the Commission on Medical Care Plans and employees in responsible positions:

"Beginning with the WPS Annual Statement for the calendar year 1961, which the Commissioner of Insurance of Wisconsin requires be filed with him by March 1, 1962, the Society must indicate the establishment of a procedure for disclosure to the Council of any material interest on the part of all councilors, officers, members of the Commission on Medical Care Plans and responsible employees which is in conflict with or is likely to conflict with the official duties of such person.

"As a basis for such procedure, the Society wishes to remind you that your relationship calls for a standard of undivided loyalty to the Society at all times. As you know, you serve the Society in a representative or fiduciary capacity.

"You must at all times not only further the Society's interests, but also avoid placing yourself in a position where your personal interests are or may be in conflict with your duty to the Society. It is not the purpose of this Statement of Policy to serve as a catalog of instances that might give rise to conflicts of interest. In general, you should avoid, directly or indirectly, participating in any arrangement, agreement, investment or other activity which could result in personal benefit at the expense of the Society's interests. You should also refrain, as should members of your family, from accepting gifts or other favors under circumstances from which it might be inferred that the gift was intended to influence you in the performance of your duties for the Society.

"*Resolved further*, That with respect to implementing such formal Statement of Policy, the Council hereby approves and adopts the following procedure:

"1. A copy of the Statement of Policy on Conflict of Interest, together with a statement for individual signature, shall be circulated by the Secretary to each councilor, officer, member of Commission on Medical Care Plans and to all employees in responsible positions. Such statements shall make provision for disclosure of any present conflict of interest and include a requirement to report any future situation creating a possible conflict of interest.

"2. The individual statement shall be completed and returned within 15 days to the Secretary of the Society for his review and report.

"3. There shall be put on the agenda of each annual meeting of the Council the report of the Secretary and a review of the corporate procedure with respect to conflict of interest.

"BE IT FINALLY RESOLVED, That the purpose of this statement is to clarify this policy for the guidance of all concerned, bearing in mind that legally and morally it is the continuing duty

of all employees and agents of the Society to represent and promote the best interests of the Society.

"Instances in which a conflict of interest situation might arise as to a councilor, officer, commissioner or employee include:

"(a) A financial interest by any such person, or a member of his immediate family, in a competing insurance organization, or any other concern doing business with the Society, unless such aggregate family interest is less than ten per cent (10%) of the equity in such concern.

"(b) Serving as a member of the board of a corporation, including a county or other medical society, which owns or operates a prepayment sickness care plan, whether on a profit or non-profit basis, whether for direct, indirect or no compensation.

"(c) Rendition by any such person of directive, managerial, advisory or consulting services to a competing organization or prepayment plan, or any outside concern doing business with the Society, or the acceptance of any outside employment that would be likely to conflict or interfere with his duty to the Society, except with the full knowledge and formal consent of the Society.

"(d) Disclosure or use of confidential Society information for personal advantage of any such person or anyone else.

"(e) Acceptance by any such person or a member of his immediate family of gifts of more than token value, excessive or lavish entertainment, or other substantial favors from any outside source which could be construed as influencing or attempting to influence the performance by any such person of his proper duty to the Society."

Individual Certificate on Conflict of Interest:

"The undersigned hereby acknowledges that he has received and read the Statement of Policy on Conflict of Interest adopted by the Council on February 25, 1962, and reports that no situation, activity or investment in which he is now involved places, or could be construed as placing him in a position of having a conflict of interest with the Society, or any of its functions, activities, operations or interests, except possibly the following:

"Any future situation, activity or investment concerning which a possible conflict of interest might arise will be reported by me promptly to the Secretary."

15. Report of Commission on Medical Care Plans

Doctor Dessloch presented the annual report of the Commission which, in essence, was intended for distribution to the House of Delegates.

On motion of Doctors James-Ekblad, carried, the Council accepted the report and expressed appreciation to the Commission on Medical Care Plans and the staff for a "job well done."

16. Adjournment

The meeting adjourned at 12:30 p.m.

C. H. CROWNHART
Secretary

Approved:

JAMES C. FOX, M.D.
Chairman

ANNOUNCEMENT OF NATIONAL BILIRUBIN SURVEY

To Be Conducted By The College Of American Pathologists

July, 1962

In order to stimulate interest in the accuracy of Bilirubin determinations the College of American Pathologists Standards Committee announces a National Bilirubin Survey, available to all physicians and hospitals.

Accurate Bilirubin measurements are of great importance in decisions as to the need for exchange transfusion in newborn erythroblastosis fetalis. They are of great importance in the differential diagnosis of the various icteric syndromes in patients of all ages. They are important in evaluating prospective blood donors. In all of these cases, a poorly calibrated technique will lead to serious mistakes in the care of the patient.

Bilirubin measurements must be consistent from year to year so that treatment is based upon the same criteria in successive patients. Therefore, reliable Bilirubin standards should be utilized with stable photoelectric photometers.

Participants will first receive a set of survey samples. Following the survey, a critique of Bilirubin Standards and methods of analyses will be provided. Questions arising during the survey may be directed to the Committee.

Those who wish to participate in this Bilirubin survey may do so by sending $8.00 to the Standards Committee, College of American Pathologists, 2115 Prudential Plaza, Chicago 1, Illinois. Applications must be received not later than August 1, 1962.

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THE EPIDEMIOLOGY AND PREVENTION OF INFECTIOUS HEPATITIS

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INFECTIOUS hepatitis is "an acute infection characterized by fever, anorexia, nausea, malaise, and abdominal discomfort, followed by jaundice. Leukopenia is usual, and bile may be detected in urine. Convalescence may be prolonged. Many infections are mild, without jaundice, and recognizable only by liver function tests; fulminating and usually fatal cases of acute yellow atrophy of liver are rare. Usually a benign disease; in epidemics fatality rarely exceeds 5 per cent and commonly is nearer 2 per cent.[1]

Infectious hepatitis is a disease which cannot be diagnosed by a specific laboratory test. Its etiological agent was only recently (1956) cultivated in tissue culture, and the first report[2] on "techniques available permitting the isolation and propagation of virus causing hepatitis in man" was published last September. However, clinical observation, pathological studies, experimentation with human volunteers, and epidemiological investigation had precisely defined this disease as a clinical and epidemiological entity.

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The diagnosis and differential diagnosis of infectious hepatitis are outside the scope of this report. Only mention will be made of serum hepatitis, a disease much more severe than infectious hepatitis but closely related to certain modes of its transmission.

EPIDEMIOLOGY OF INFECTIOUS HEPATITIS

Etiological Agent. Typical cytopathogenic effects were produced in 1956[2] by viral agents recovered from serum of patients suffering from infectious and serum hepatitis. These agents were maintained in tissue cell cultures. The techniques of tissue culture were improved, and a recent publication by Boggs[2] describes clinical trials of successful transmission of these agents to human volunteers causing infectious hepatitis. All agents isolated remained viable when heated to 60 C. (140 F.) for 30 minutes. They were resistant to ether treatment and unaffected by antibiotics.

The virus particles appear as single or clustered spheres of 8 to 12 millimicrons in diameter as seen in the electron microscope. These agents are very small as compared to the large viruses such as the herpes simplex virus, being about one-half the size

of the very small polio virus. Preliminary serologic studies reveal that there are at least three groups of culturally similar viruses. Two of these can cause clinical hepatitis when given to volunteers.

A major problem at the present time is the typing of many viruses recovered in tissue culture from hepatitis cases. The work in progress promises the development of techniques for routine isolation of the virus from specimens obtained from patients as well as specimens from their environment. The ultimate goal of the research is the development of antigens for serologic tests and the production of a vaccine giving active immunity against this disease.

Incubation Period. The incubation period of infectious hepatitis varies from 10 to 40 days, being commonly 25 days as observed in epidemiological studies. Krugman[2] observed a wider range in the incubation period in his experiments of feeding stool filtrates to inmates of the Willowbrook Institution for Mentally Retarded Children. The longer incubation period may be explained by secondary infection from symptom-free shedders of the virus. In his experiments, anorexia and vomiting occurred two to three weeks after feeding. The liver became enlarged one or two weeks before the jaundice occurred. Liver function tests became positive one or two weeks before the onset of the icterus.

Period of Communicability. The infectivity of patients in the incubation period as well as for a period following clinical recovery is well established. The Krugman studies[3,4] show that the secretion of the virus in the stools starts 2 to 3 weeks before onset of jaundice. The presence of infective material in the blood during the incubation period was also demonstrated. There is evidence of a fecal carrier state for 5 to 15 months, and a chronic carrier state was postulated. Feces and blood may be infectious for several months after clinical recovery. However, epidemiological experience[1] shows greatest communicability for a few days before to a few days after onset, usually not exceeding 7 days.

Age and Sex Distribution. Both sexes are equally susceptible to this disease. The age distribution depends upon the epidemic pattern. For example, outbreaks in the armed forces, tropical areas, et cetera, have their own age distributions. Data from civilian populations in the United States shows the highest morbidity rates in the age group of 5 to 14 years. Mortality tends to rise, just as with other virus infections, with age. Hepatitis in children is a relatively mild disease, but it can be severe in adults. Females in the third trimester of pregnancy are more severely ill. Mortality[6] seems to be higher among younger females in general. The mortality of males over 50 years of age is in excess over the females.

Geographic Factors. Infectious hepatitis appears to be world-wide. However, certain areas such as the Mediterranean countries and Germany have a higher incidence of this disease.[6] Wherever the German army invaded countries during World War II, the incidence of infectious hepatitis was higher.

Social Factors. Malnutrition adversely influences the clinical course. Crowding and unsanitary living conditions favor the spread of infectious hepatitis as they do for any disease transmitted from fecal discharges. There was a curious phenomenon observed in the allied armies[6]—the officers showed a higher rate of hepatitis than enlisted men. In the adult population, the shellfish-transmitted hepatitis shows a greater incidence among males, probably because they frequent bars and other drinking establishments where raw oysters and clams are consumed.

Seasonal Distribution. The number of reported cases of hepatitis in the United States shows a marked seasonal variation.[7] The peak prevalence usually is reached in February and March, with a decline in the summer months and an increasing number of cases in October and November. This is in contrast to the trend seen in poliomyelitis epidemics. This phenomenon is puzzling if we consider the usual source of infection in both diseases to be the oropharynx for a few days during late incubation period and the period of prolonged fecal discharge of virus after recovery. The same can be observed with diarrheal diseases which spread through fecal discharge and are more prevalent in the summer months.

Reservoirs and Vectors. The infectious hepatitis virus is found in the blood and alimentary tract of man. Chimpanzees are suspected carriers of this virus.[7] Three distinct outbreaks were reported from pet shops and workers in a primate colony. Water can transmit hepatitis if it is contaminated with sewage. Clams and oysters

are also known vehicles of transmission. In the outbreaks investigated, the clams and oysters transmitting the disease were harvested from beds near sewerage outlets. Food-borne epidemics have also been described; and milk was implicated in one epidemic, probably caused by using rinse water from a contaminated well. No evidence is available to show transmission of the disease by biting insects[6] even though only a small amount of blood is needed for transmission to occur with contaminated syringes. However, it is believed that mechanical transmission by insects such as flies or roaches is possible. The seasonal distribution of cases suggests that insects do not play a major role in the epidemiology of the disease.

PATTERN OF OCCURRENCE

1. Hepatitis in the General Population

Infectious hepatitis was made reportable after World War II with national statistics being collected first for the year 1952. A peak number of cases reported occurred in 1954 in the United States and 1955 in Wisconsin. The second peak occurred both in the United States and in Wisconsin in 1961. A five to seven-year cyclic increase of cases has been noted also in other countries. This cyclic behavior is known in the epidemiology of other viral diseases such as measles.

There is no detailed information available for the previous years and the Wisconsin data gives only the total number of cases.

Eighty-five per cent of the cases reported in 1961 occurred in young adults or children, strengthening the impression of many investigators that[8] "infectious hepatitis is to be regarded as one of the more common diseases of childhood." Table 3 shows the decreasing percentage of cases with advancing age. The pattern is similar to many other infectious diseases of childhood. An attack of infectious hepatitis apparently gives lifelong immunity. In contrast with other contagious childhood diseases, the number susceptible is still great among adults as proved by the high incidence of cases in the adult population. The sex distribution among adults as in children is approximately equal. Regional variation of the number of adult cases was observed and the same applies for distribution of the sex ratio. This can be explained by the great number of shellfish-transmitted cases among adult males in 1961. The age and seasonal distribution of the total cases shows that the majority of the cases occur in school age children during the school year.

It should be noted that only 21 per cent of the adult cases gave a history of contact with known hepatitis cases. The appearance of numerous adult cases in a community should alert physicians and public health workers that there is an unusual pattern of the disease transmission.

TABLE 1—*Reported cases of hepatitis*

Years	No. Cases in U.S.A.	Rate 100,000 Population	Wisconsin No. Cases	Rate 100,000 Population
1952	17,428	11.8	102	3.0
1953	33,706	21.7	352	10.1
1954	50,093	31.1	653	15.4
1955	31,961	19.5	733	20.0
1956	19,234	11.5	333	8.9
1957	19,922	8.8	240	6.3
1958	16,294	9.4	251	6.5
1959	23,574	13.4	256	6.6
1960	41,020	23.1	234	5.9
1961	72,577	40.3	403	10.0

TABLE 2—*Age distribution of reported cases of infectious hepatitis 1961*[7]

Age	Number	Per Cent
Less than 20 years	61,316	84.5
Over 20 years	11,241	15.5
Total	72,557	100.0

TABLE 3—*Per cent distribution of 11,241 cases of hepatitis reported in persons over 20 years of age in the U.S.A. in 1961—by age groups and sex*[7]

Age Group (years)	Per Cent Male	Per Cent Female	Per Cent Total
20–29	22.4	19.4	41.8
30–39	16.9	13.3	30.2
40–49	7.8	6.0	13.8
50 and over	6.7	6.1	12.8
	53.8	44.8	98.6
Unknown			1.4
			100.0

TABLE 4—*Per cent of adult cases of infectious hepatitis reported in the U.S.A. (11,241) in 1961—giving history of contact with previous case*

Contact	Per Cent
Family	10.4
Other	10.9
No Known	73.5
Not Given	5.2
	100.0

2. Some Examples of Hepatitis Outbreaks in Wisconsin

a) *Infectious hepatitis in Sharon.* Twenty-four cases occurred in Sharon, a community of 1,000 population, between July 1956 and February 1957, half of them among school children. Tabulation of the cases by date of onset showed a clustering of cases in three to four week intervals. This is the usual incubation period and is typical of a contact type of spread in an epidemic. Gamma globulin was administered in February 1957 to 423 school children in doses of 0.01 ml. per pound of body weight. Five cases of hepatitis occurred within one week of administration of gamma globulin and three additional cases were observed during the following week. This is an unusual failure of gamma globulin prophylaxis. A sanitary survey in this community disclosed unsafe water and an unsatisfactory sewerage system. Eight adult cases had no known immediate contacts with families which had hepatitis cases among the children. The possibility of spread by contaminated wells was considered. Massive infection by contaminated sewage may explain the failure of gamma globulin prophylaxis in the dosage given.

b) *Hepatitis in Sun Prairie.* Thirty cases occurred in Sun Prairie (population 1,500) between December 1956 and March 1957. Twenty-five cases occurred among the school children; one case (a family contact) in a preschool child and four cases among adults who all had family contact to school children. Twenty families had cases, where children were pupils of the public school; no cases were observed among children in parochial schools. Gamma globulin was administered by private physicians to family contacts. No secondary cases occurred among 78 family members receiving gamma globulin and 2 cases occurred among 19 family members not receiving gamma globulin. This is a typical description of a hepatitis outbreak as usually seen in Wisconsin.

c) *Hepatitis among the Menominee Indians.* Twenty-eight cases occurred between October 1960 and February 1961: 22 cases were among school children, 5 cases in preschool age, and 1 adult case. Gamma globulin was administered in doses of .01 ml. per pound of body weight in February. Only 2 additional cases occurred after this time in patients not receiving gamma globulin and exposed to known cases in the family. The low number of adult cases can be explained by the more primitive sanitary conditions among these people so that adults had previous chance to acquire immunity by exposure to this virus.

3. Hepatitis in the Military Population[6]

Outbreaks among military personnel have been noted for many years. Crowding and poor sanitary conditions during combat favor spread of infection from the fecal route. A common type of transfer in the military is the person-to-person transmission.

During World War II the extensive use of injectibles caused a great number (over 50,000 cases) of hepatitis. This will be reported later.

4. Institutional Outbreaks

Orphan asylums, boarding schools and mental institutions[3,6] reported several outbreaks in children. Krugman et al.[3,4,5] report a detailed study of hepatitis in a New York institution for the mentally defective. This institution cares for about 3,500 to 4,000 patients with an admission rate of 15 to 20 per week. During the observation period of 1953 to 1956, 256 cases were noted. Forty per cent of them occurred in the summer months with 70 per cent being among persons younger than 20 years of age. Cases that developed six months after admission proved that they acquired the disease in the institution. The disease among children was very mild. Symptoms were innocuous and the duration of the illness was very short. It is possible that in many institutions the disease occurs in such a form that it is not recognized.

Another outbreak reported from Colorado included 52 cases among 776 patients between the months of June 30, 1960, to September 30, 1961. Only 65 per cent of the cases had jaundice; most of the children had only bile in the urine and liver enlargement. The symptoms were mild and the duration of the icterus at times was only 2 to 3 days.

5. Water-Borne Outbreaks

Sewage contamination of water supply can cause an epidemic of hepatitis. This type of outbreak is sudden and explosive. A great number of cases appear within a short time period, with adults and children of both sexes being infected.

During the months of December 1955 and January 1956, 3,786 cases of hepatitis were reported in Delhi, India.[6] A sampling survey by house-to-house inquiry obtained an estimate of 30,000 icteric cases in a population of 1.5 million. According to estimates, 70 per cent[6] of the cases occurring in an epidemic are nonicteric so that the final estimate of 100,000 cases was considered the incidence for these two months. The sampling survey revealed that the majority of cases occurred in an area supplied by a single water system which was contaminated by sewage from November 10 to 16, 1955. Age distribution showed more cases in the younger age group, but it is puzzling why so many adults develop hepatitis in a population where the poor sanitary conditions might have produced exposure and developed immunity during previous years. Possibly the sudden massive invasion by the virus neutralized the existing antibodies and permitted reinfection.

Several water-borne epidemics were reported in the United States, including those in Tennessee, Connecticut, and West Virginia during 1960.[8]

The only water-borne outbreak in Wisconsin tabulated in the State Board of Health files occurred between October 1947 and July 1948 in Merrill and vicinity. Seventy-eight cases in 49 families were observed during this period. The attack rate was 4.8 per thousand population; 32 cases occurred in the age group 20 years and over. Careful inquiry of contacts revealed that at least three independent foci of infection were operating. The cases were concentrated on the east side of the Prairie River. The elevation west of the river is higher than the east side. Many residents used water from privately owned wells which were shallow. Repeated analysis showed a high Bacillus coli count. This investigation was carefully done and it was concluded that a continuously contaminated private well system in the community was the mode of spread of hepatitis. This is not a typical example of an explosive water-borne outbreak.

6. Food-Borne Outbreaks

Hepatitis may be spread by consumption of raw shellfish (oysters and clams).

a) *The Swedish Outbreak.*[6] Six hundred and thirty cases of hepatitis were observed in the period from December 16, 1955, to January 15, 1956, in Sweden. These cases occurred in 3 large cities and over 100 small towns. The unusual feature was the age and sex distribution in this outbreak. There were no children involved, the majority of the patients were males, and 90 per cent of the cases belonged to the upper socio-economic groups. The cases observed gave the history of consumption of oysters, all of the supply coming from a single fishing village. The incriminated shipment of oysters was stored in sea water in the harbor for about 10 days. Flush toilets empty into the sewerage lines in the village and the untreated sewage is emptied into the harbor. A typical case of hepatitis was observed in a person in this village who became ill on November 24. Fifty per cent of the consumers of the shipment became ill with hepatitis.

b) *The Pascagoula Outbreak.*[8] During the first three months of 1961, 77 cases of infectious hepatitis were observed in Mississippi and Alabama. Epidemiological investigation disclosed that all patients consumed raw oysters originating from an oyster bed at the mouth of the Pascagoula River. They were harvested in a single area near the sewage polluted river. The cases were predominantly adults, more males than females, and many belonged to the upper and mid socio-economic group. Closing of the oyster beds in the area terminated the outbreak.

c) *The Raritan Bay Epidemic.*[8] In March, 1961, tabulation by the New Jersey State Health Department revealed that 77 per cent of the cases reported for this month were persons over 20 years of age with a higher proportion of males. A similar concentration of cases was observed in Rochelle and Westchester counties in New York. Histories of raw clam consumption were found frequently among patients in New Jersey and Nausau counties but were relatively rare elsewhere. Extensive epidemiological investigation pinpointed the source of the clams consumed by cases with "definite" history of eating raw clams to Raritan Bay in New Jersey. The shipment of clams involved was harvested during the winter months where the only unfrozen part of the water was near a sewerage outlet. Seven hundred and seventy-one adults consumed raw clams 10 to 50 days prior to the onset of infectious hepatitis. In 664 cases the source of the clam supply could be traced; 443 cases were traced to suppliers from the Raritan Bay area. Seventy-five per cent of

the cases belonged to the upper and middle socio-economic group. The highest proportion was in ages 20 to 29 years with 75 per cent of the patients being male.

In this investigation more than 1,000 patients were questioned, 1,200 eating establishments, distributors, and other suppliers were visited, their services checked, et cetera. On May 1, 1960, the waters around Raritan Bay were closed to the harvest of shellfish.

No oyster-associated cases have been reported since the closing of the Pascagoula oyster beds. Adult hepatitis cases with histories of clam eating continue to be observed in New York and vicinity where raw clam consumption is common. Close surveillance is needed to find common foci of shellfish—associated cases.

d) *A Bizarre Story.* Twenty-two officers stationed at a naval base developed infectious hepatitis with onset between November 18 and December 13, 1961. The only possible common place of exposure was in the bachelor officers' quarters. In the week of October 23, 1961, all but five of the officers ate the noon meal on October 27; four ate the noon meal on October 26, and the fifth patient ate the evening meal on October 26. The patients and 130 other individuals with no illness were questioned about meals consumed. Tabulation revealed that potato salad was the only likely food to be suspected as the vehicle of transmission.

Search was made to locate a carrier of hepatitis virus among personnel of the kitchen of the bachelor officers' quarters. One man, the salad handler, was ill for two weeks with anorexia and diarrhea with onset October 10. This man was exposed to a family with typical infectious hepatitis. The salad handler was seen by pyschiatrists in September, 1961, for "unusual behavior pattern." Inquiry from this person, his wife, and a police officer about his erratic behavior raised the possibility that he contaminated the salad dressing with his urine. Kitchen records showed that one gallon of dressing was made each day, 75 per cent of which was used for potato salad. The contamination of a single bottle of dressing was a distinct possibility.

This was the only case report that could be found that pointed to the possibility of discharging virus from the genitourinary tract. Further work in this area will be done using tissue culture techniques in the future.

7. Transmission of Hepatitis by Parenteral Injections

Both infectious hepatitis (Virus A) and serum hepatitis (Virus B) can be transmitted by injections if the syringe has traces of blood of an infective person. Infections by Virus A can be transmitted both by the oral and parenteral routes; serum hepatitis by injections only. Virus A is demonstrable both in blood and feces; Virus B in blood only. The incubation period of Virus A is 10 to 40 days wheras serum hepatitis has a longer incubation period of 60 to 160 days. Infectious hepatitis tends to have an abrupt onset with fever. Serum hepatitis has an insiduous onset with low-grade fever. Gamma globulin is effective for prophylaxis in infectious hepatitis only. No cross immunity develops between the two types of hepatitis.

Serum hepatitis is a severe disease with a case fatality rate of 30 per cent or more in sick and debilitated patients.[6] Among the three million army personnel receiving yellow fever vaccinations, about 10,000 cases of hepatitis occurred with a fatality rate of 0.3 per cent.[8] In 1940, 50,000 cases of serum hepatitis followed a mass inoculation program against yellow fever in Brazil. In 1942, yellow fever vaccine given to 90,000 persons in Brazil caused 1,000 cases of serum hepatitis with 24 deaths giving a case fatality rate of 2.5 per cent. The ratio of fatality increased with the age of the patient. A review of the literature by seven investigators[8] gave a range of hepatitis following whole blood injections of 0.1 to 1.15 cases per 100 units of blood or 0.26 to 4.15 cases per 100 recipients. The blood and plasma infusion-caused hepatitis will not be presented in this report.

a) *Hepatitis Observed Following Antiluetic Treatment in Clinics.* Cases of hepatitis observed during antiluetic treatment with arsenicals were interpreted by many clinicians as "luetic hepatitis" or hepatitis caused by the arsenicals. Runge,[6] in 1931, carefully studied the so-called "arsenical jaundice" in the German navy. He found that there was an incubation period of two to three months. It was demonstrated that if traces of blood were left in an uncompletely sterilized syringe, it can cause hepatitis. The peak of the "arsenical hepatitis" occurred some two months after the peak of hepatitis cases in the general population.

Studies in the British navy,[6] in 1941, 1942, and 1943, showed similiar findings. An improved method of sterilization of syringes and needles was associated with the sharp decrease of hepatitis in luetic clinics. Waeelk[6] described an outbreak of hepatitis in an antiluetic clinic in Germany in 1948. That year two types of incubation periods were observed; one appeared 4 to 8 weeks after the beginning of the treatment and the second type appeared 16 to 20 weeks after the initial injection. There were several patients who had hepatitis with a short (22 days) incubation period. They apparently recovered and had a second attack with the long incubation period. It can be assumed that these patients were infected with both A and B viruses and the infection with Virus A did not give protection against the disease caused by Virus B.

Hepatitis outbreaks were described after injection with penicillin, thiopental sodium, insulin in the diabetic clinics, and other drugs even after simple withdrawal of blood.[9]

b) *Hepatitis Deaths in the Practice of a Single Physician.*[7] In October 1960 the Pennsylvania State Health Department reported to the New Jersey Health Department a comatose patient and two deaths from hepatitis. All were patients of a New Jersey physician. Investigation revealed that among the patients of this physician, specializing in psychiatry and using a variety of injections, 40 cases of hepatitis with 14 fatalities occurred between May 1960 and January 1961. There were 21 male and 19 female patients with 4 males and 10 females dead from the disease. Incubation periods, clinical cause, and autopsy reports were consistent with the diagnosis of serum hepatitis in all fatalities reported.

c) *Hepatitis Following Tattooing.* Thirty cases of serum hepatitis, including 13 cases in 1961, were observed in New York since 1959–1961 following visits to a tattoo parlor. This prompted the New York City Department of Health to issue a directive that tattooing of humans could be done only by persons licensed to practice medicine. It was estimated that about 10,000 persons were tattooed annually in New York.

d) *Tuberculin Testing and Hepatitis.* Intensive search of the literature failed to find a report of spreading hepatitis by the use of multiple dose tuberculin syringes. Maxcy and Rosenau's *Preventive Medicine and Public Health* [10] states that:

> "There is little evidence regarding the hazard of intracutaneous administration of skin-testing antigens, such as tuberculin, out of the same syringe. There is considerable advantage in ease of administration and economy of material when a 1-ml. syringe is filled and 10 successive intracutaneous injections given from it, the needle being flamed or changed between injections. The danger in this is probably too remote to outweigh its advantages. However, a tuberculin syringe should be discarded and resterilized when empty."

REPORTING OF HEPATITIS

The Public Health Service started the Communicable Disease Center hepatitis survey reports on April 29, 1960. Since that time a great amount of important information was gathered by the CDC from state health departments and later through local health departments. The basic information is always obtained from practicing physicians. Reporting cases of infectious and serum hepatitis is the obligation of every medical practitioner. Only careful analysis of the reported data can shed more light on the epidemiology of this important disease and only through reports from practicing physicians can we start meaningful measures to control it.

The importance of prompt reporting of hepatitis seen by private physicians cannot be overemphasized. The usual pattern of outbreaks in Wisconsin is a school-centered epidemic with secondary cases among the adults. If information is available, any deviation from the usual pattern can be immediately noted. Cases among adults other than contacts with school children should be investigated for possible transmission of the disease by water, food, injections, or other modes of transmission. When the mechanism of transmission is found, rational procedures can be employed to prevent further cases.

PREVENTION OF HEPATITIS

Asymptomatic and subclinical cases are just as infectious as the frank cases. They can transmit the disease at the end of the incubation period. Isolation of cases seems the most logical way to prevent contact infection, but the factor mentioned above makes the effectiveness of this procedure

limited. The Wisconsin Administrative Code requires isolation of cases for seven days. However, good personal hygiene must be practiced for several months because the fecal and possibly the bladder discharges are infectious.

The Public Health Service published an excellent monograph on *Viral Hepatitis, Clinical and Public Health Aspects** in which the following recommendations are made:

Recommended Procedures for Hospitals:

a. Establish a unit where all hepatitis patients can be cared for and where unit isolation rather than individual isolation can be practiced. If possible, nursing and auxiliary staff assigned to this unit should not care for other patients.

b. Instruct nurses in the importance of appropriate techniques:

   (1) Patients should have individual equipment such as thermometers, bedpans, and utensils.

   (2) The attendant should wear a gown to protect the uniform during the time that nursing care is given and the patient's equipment is handled.

   (3) Bed linens of hepatitis patients should be handled separately from other linen. Separate containers should be provided so that contaminated linen can be placed in the communicable disease (CD) laundry bag at the door of the room or unit. The bag should be closed when not in use and while in transfer to the laundry. Laundries usually wash contaminated linen after other hospital linens. The laundering processes used in modern institutions are usually adequate to free soiled linen of pathogenic material.

   (4) Disposable paper cups and dishes are recommended. When these are not practicable, the patient's utensils should be handled separately, but may be washed with other dishes since the machines employed will usually clean them sufficiently to remove all infectious material.

   (5) Nurses, attendants, and physicians should wash their hands thoroughly immediately after handling patients or any equipment or supplies that came in contact with them.

   (6) Bedpans should be sterilized, either by steam under pressure after each use, if possible or by boiling for 15 minutes at least once a day. In disposing of stools and urine, bedpans may be emptied directly into the hopper or toilet if the hospital wastes enter a treated municipal sewerage system or proper septic tank. Liquid and solid food wastes should be handled in the same way.

c. Administer gamma globulin in a dosage of 0.05 ml. per pound of body weight to nurses, laboratory workers, and auxiliary staff caring for hepatitis patients. Caution them that while they may show no signs of hepatitis because of the passive protection received, they may still be able to transmit the infection to others. Gamma globulin, therefore, is no substitute for cleanliness.

d. Autoclave all needles, syringes, glassware, and instruments used for intravenous, intramuscular, or subcutaneous injections for at least 30 minutes at 15 lbs. of pressure after each use. Individual syringes and needles must be used. Lancets used to obtain capillary blood for laboratory determinations should be disposable.

e. After a patient's discharge, sterilize with steam all articles of equipment that can be handled in this manner. Those which would be damaged by heat or which do not lend themselves to this type of sterilization should be thoroughly cleaned with soap and water and soaked for 24 hours in a solution of 0.5 per cent iodine and 70 per cent ethyl (or isopropyl) alcohol. Thermometers should either be given to the patient to take home or should be cleaned and sterilized by the latter method.

f. The collection of blood from donors for transfusions should be discontinued and blood should be obtained from other

*A copy of this document is available from the government printing office as Public Health Service Publication No. 435, 1959.

areas until the outbreak is at an end. This is suggested because it has been shown that the virus of hepatitis A exists in the blood stream during the incubation period and the early acute stage of hepatitis.

DOSAGE OF GAMMA GLOBULIN

The Wisconsin State Board of Health's current policy for gamma globulin distribution, August 1961, states:

> "*INFECTIOUS HEPATITIS*: For close contacts to clinically diagnosed cases regardless of age the recommended dose is .01 to .02 ml. per pound of body weight."

The classical study of Stokes and Neefe, in 1945,[11] demonstrated the effectiveness of gamma globulin in dosages of .015 ml. per pound of body weight in prevention of the development of clinical form of infectious hepatitis. Several studies[12] reported since then have shown effectiveness of the dose of .01 ml. per pound of body weight in children and adults. Krugman et al.,[5] published their study in October 1960 recommending the optimum dosage for children and especially for adults as .06 ml. per pound of body weight. The American Academy of Pediatrics accepted the Krugman recommendation in their 1961 edition of their *Control of Infectious Diseases.* The hepatitis subgroup of the Commission of Virus Infections of the Armed Forces Technical Bulletin recommends a dosage of .05 ml. per pound of body weight. This group financed the Krugman studies.

The five to six-fold increase of the recommended dosage for use of gamma globulin for prevention of hepatitis caused considerable alarm among official agencies responsible for distribution of the free gamma globulin supplied by the Red Cross. A review of this problem can be found in the *New England Journal of Medicine,* June 15, 1961, issue, Volume 264, No. 24. A large study from California[12] shows that the dosage in .01 to .02 ml. was effective in 90 per cent of the cases among 1,100 inoculated cases using 929 controls. It should be noted that the Krugman study refers to an institutional situation where the hygienic conditions are very poor due to the low mentality of the patients and in the large wards the viruses circulate continuously.

Because of the shortage of gamma globulin available for free distribution by the State Board of Health and the demonstrated effectiveness of the dose of .01 to .02 ml. per pound of body weight, gamma globulin is available upon request to practicing physicians only in the above dosages. The use of gamma globulin is restricted to close contacts, such as members of the household where a patient with hepatitis resides or for a guest who has spent 24 hours within the household or for employees who are close contacts of an institutionalized patient or for close contacts with a patient occurring in a school. If in the judgment of the practicing physician gamma globulin is indicated in larger doses or in cases other than close contacts, gamma globulin must be provided from commercial sources.

Active-Passive Immunity. The half life of gamma globulin is about four weeks.[5] It was observed that contacts receiving a single dose of gamma globulin are protected even if they are exposed for a prolonged period to hepatitis virus. Stokes suggested a mechanism of active-passive immunity whereby the passive immunity supplied by the gamma globulin suppressed the development of clinical signs of hepatitis infection but the virus is still active to stimulate formation of antibodies and thus provide active immunity. In most published studies the measure of effectiveness of protection given by gamma globulin was the absence of jaundice. Krugman[6] noted that serial biochemical tests for liver function were positive even after a dose of .06 ml. per pound of body weight in 9 patients out of 17 observed. Three of these patients had jaundice. However, the icterus was so mild that under ordinary circumstances the attendants on the ward would not discover it. The probability of the presence of active-passive immunization is supported by this study. In view of these findings *a repeated dose of gamma globulin during the course of ordinary family type of hepatitis exposure is not indicated.* Krugman observed protection from gamma globulin in doses of .06 ml. per pound of body weight in adults.[6] This protection was effective for over one year in his institutional situation.

Gamma globulin is not effective in treatment of infectious hepatitis.

Pregnant women, especially in the third month of pregnancy, have a more severe form of this disease. Persons in poor nutritional states and those exposed to toxic

agents also need special protection. Household contacts are exposed continuously and need protection more urgently than casual contacts.

SUMMARY

The epidemiology of infectious hepatitis has been reviewed. The majority of cases in the United States occur in school-centered outbreaks. Transmission by other than person-to-person contact such as water-borne disease and transmission of hepatitis by contaminated food, especially raw shellfish and through contaminated syringes, changes the pattern of the epidemic. The clustering of cases in adults who are not contacts with sick school children suggests an unusual mode of transmission. This pattern can be observed only if hepatitis cases are promptly reported by practicing physicians.

Preventive measures recommended for use in hospitals and private practice have been outlined. The dosage and availability of gamma globulin has also been presented.

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LABORATORY NOTES No. 3 of a series

VIRAL HEPATITIS

Viral hepatitis may be of two types. Infectious hepatitis, caused by virus A, or homologous serum hepatitis caused by virus B. Infectious hepatitis is transmitted by ingestion of contaminated food or drink. Serum hepatitis is transmitted by parenteral inoculation of the virus in medications, blood transfusions or transfusions of blood products or from contaminated hypodermic needles and syringes. The incubation period varies with some degree of overlap. Infectious hepatitis has an incubation period from two to three months and homologous serum hepatitis has an incubation period of from 30 to 60 days.

The viruses responsible for hepatitis cannot be grown outside the human body, therefore animal inoculations for recovery or culturing in tissue cultures are of no value in the laboratory diagnosis of viral hepatitis. The complement fixation test has not been successful as a diagnostic tool. There are many laboratory tests which may be used to aid in the diagnosis of the disease. None of these tests actually measures the presence of the virus but instead measures the degree of damage done to the liver. Thus the diagnosis is established through indirect methods.

Prepared by S. H. Holt, M.D., Director of Laboratories, Kenosha Hospital, Kenosha, Wisconsin.

LABORATORY FINDINGS

1. Elevated isocitric dehydrogenase.
2. Normal hemoglobin.
3. White blood cell count normal or low.
4. Normal hematocrit reading.
5. Lymphocytosis on differential smear.
6. Atypical lymphocytes frequently present.
7. Heterophil test is usually negative (may be low positive).
8. Urine urobilinogen is elevated.
9. Bromsulphalein excretion is reduced.
10. Increased serum bilirubin.
11. Cephalin-cholesterol flocculation test is usually positive.
12. Thymol turbidity test usually is positive.
13. Thymol flocculation test is usually positive.
14. Zinc sulfate turbidity test is usually positive.
15. Cholesterol esters are usually reduced.
16. Total cholesterol is usually normal.
17. Normal or slightly elevated serum alkaline phosphatase.
18. Blood serum amylase is usually reduced.

DO YOU KNOW?

Between 1936 and 1956, the prices of various services rose by the following percentages: Hospital room rates, 265%; men's haircuts, 220%; shoe repairs, 135%; general practitioners' fees, 72%; surgeons' fees, 59%.—YOUR HEALTH, Pennsylvania Medical Society, Dec. 21, 1961.

Ulcer-prone children can be recognized when doctors become familiar with the children and the problems of their parents. Doctors must act as firemen to quiet the internal fires which lead to a crater formation.

"RED ALERT" FOR DUODENAL ULCER IN CHILDREN

By MARGARET PROUTY, M. D.

Madison, Wisconsin

THE MEDICAL press is recording the alarming increase of childhood ulcers with such headlines as "Ulcers Termed 'Common' in Children," "Peptic Ulcers Found Increasing in Young from 4 to 12 Years Old," and "Peptic Ulcer in Children Seen as Frequent Occurrence."

In a 10-year study at the Quain and Ramsted Clinic, Bismarck, N. D., ulcers were diagnosed radiologically in 10 per cent of children referred for gastrointestinal examination. Dr. Roger M. Berg, reporting on these findings, said, "In our experience, ulcers are more common than diseases such as diabetes or rheumatic fever." The findings in my own practice verify this statement. The number of cases discovered is increasing yearly. In the 12 months ending March, 1961, my colleague, Dr. Dorothy Oakley, and I diagnosed 34 new cases of ulcer, confirmed by roentgen examination. A few x-ray films came back on which the roentgenologist commented: "changes consistent with an ulcer although no crater could be demonstated." These we have termed a "pre-ulcer."

Without exception each child in our series had emotional problems—many of them so grave that they could not be solved, others of a temporary nature, which could be alleviated by the parents after they had gained insight into the child's problem or by psychiatric referral. Doctor Oakley and I contend the danger signals are present long before the abdominal pain appears; the ulcer-prone child can be recognized when we become familiar with the child and the problems of his parents. As pediatricians we must act as firemen to quiet the internal fires

From the Department of Pediatrics, Jackson Clinic, Madison.

which lead to a crater formation. The following three cases show the emotional factors responsible for the complaints, the common presenting symptoms, and the personality types encountered.

CASE REPORTS

Case 1—This 6½-year-old boy had intermittent epigastric pain for one year. Increasing in intensity, it became a daily complaint. The pain had no relation to meals and would come at any time of the day; twice it awakened him in the night. Soon after the onset of pain he vomited without nausea and was relieved of his symptoms. His appetite was good; if food was vomited, he could immediately eat again. An x-ray film taken six months earlier showed no pathology. A repeat of this procedure showed a small ulcer on the posterior wall of the duodenum and changes consistent with an old healed crater on the greater curvature of the stomach.

The mother was overly concerned, almost phobic, about the safety of her children and was emotionally disturbed to the point of having to seek psychiatric help. Because of his own insecurity, the father tended to bow to his wife's judgment, which, overridden by fear, was not always as sound as his. This tended to increase the already strong divisions within the family. Until the previous year this boy had been reared largely by his maternal grandparents and continued to spend much time in their home. Even now they carry the chief role of parents, which confuses the child.

His mother complained that the child could not sit still and was in motion all the time. She blamed the father for the child's problems, saying that the father "rode" him, nagged, and scolded all the time. The boy's complaints were severe enough to warrant hospitalization. On the same medication to which he had failed to respond at home his pain promptly subsided in the hospital except when his mother visited him. The nurses spoke of him as "smarty" and inclined to give "back talk" and were unanimous in their observations that he minded poorly. When released from the hospital, his pain returned, although it moved from the epigastrium to the periumbilical area. An x-ray film taken three months after hospitalization showed healing of the crater. The mother demanded more and stronger medications for him until suddenly in May I heard nothing further from her.

Eight months later, she brought the boy in for an unrelated complaint, and I was struck by the calmness of both parent and child. She could hardly wait to tell me of the improvement in her boy. In May she had had a sudden lung collapse and had been hospitalized for 2½ months. The father had taken over the care of the two children, and it appeared for the first time that the father and son had begun to understand each other. They became friends and enjoyed doing things together. The mother appeared relaxed, while the child was no longer sullen and uncooperative. The mother volunteered that the change in the family was worth the pain and expense of her long hospitalization.

Case 2—This 5-year-old girl had a sudden onset of epigastric pain five days before she was seen. The pain occasionally caused her to double over, and she cried repeatedly because of its intensity. Food intake of either solids or liquids caused nausea, although she had not vomited. Food and water were eventually refused. X-ray examination showed a marked degree of hyperactivity of the stomach with prominence of the rugae.

There was increased peristalsis and a marked degree of pylorospasm. The duodenal bulb appeared irritable and hard to fill. The changes were consistent with an ulcer, although no crater could be demonstrated. She was given an antispasmodic and antacid and sent home on a regimen, but after two weeks of only minor improvement she was hospitalized.

She formed a satisfactory friendship with a wardmate of her own age and within two days had no more pain. In the office she had always been too shy to answer questions. There was never spontaneous verbal expression and she sat mouse-like with her chin on her chest. Her behavior soon changed under hospital conditions, she talked incessantly, played noisily with her friend; and when I opened the door, she would skip the length of the hall, take hold of my hand confidingly, and climb up on my lap while I looked at the charts. The only complaint of pain after the second day occurred when her companion was moved into another ward, but the pain disappeared when she found that their shared activities were not curtailed.

This child was the product of a second marriage for the mother. The father often brought the child to the office as she had more infections throughout her lifetime than any other child in my experience. In spite of gamma globulin, prophylactic antibiotics, and removal of her tonsils and adenoids, her repeated infections continued until an anabolic metabolite was given. The father was almost as uncommunicative as the child and impressed me as "Mr. Milquetoast." This impression was in error because he was a roaring bully at home. The mother has been institutionalized in a mental hospital intermittently because of her own emotional problems while the half-sibling is schizophrenic, a school delinquent, and is at present confined in the State School for Girls. The emotional tangle in this family seems at present incapable of being solved.

Case 3—A 6½-year-old-girl, eager to tell about her complaints, gave an excellent history with very little prompting from her mother. For four weeks she had awakened each morning with midabdominal pain. "I get 'hot spit' and then throw up," she said. She was then relieved of her pain. If she did not vomit before going to school, she vomited after she got there and the teacher had to keep a basin at her desk. Pain and nausea were present daily except on Saturday.

I obliquely inquired about school and her teacher. She liked both and her marks were excellent. I asked if anyone bothered her at school. The floodgates were opened; she poured out a tale about a girl in her class who stamped on her toes, kicked her shins, pinched, and bit. "Everyone is afraid of her," she said, "even the boys." "What do you do when this bully picks on you?" I asked. "I don't do anything," she answered. This, of course, was the crux of the matter.

The mother volunteered that she not only had pain and vomiting but also had started to suck her thumb. Home conditions were serene, and the wise mother was aware of the cause of her daughter's distress but did not know how to alleviate it. An ulcer crater was demonstrated on the posterior wall of the duodenum, and medications and a regimen were prescribed.

In talking with the child I told her that "the next time that bully picks on you I want you to look her right in the eye and say to her, 'Now see here, the next time you do that I'm going to hit you just as hard as I can.'" The child reacted with horror. "I wouldn't dare," she said. "Why not?" I insisted. "Teacher wouldn't like it," this little conformer replied. I promised that I would write to the teacher and explain the situation. The child was not sure that she could bring herself to carry out my recommendations, but she took her medications faithfully and in one month returned with a broad smile. Within a week she had stopped having pain and vomiting. "What happened to the bully?" I inquired. "She doesn't have any friends and now I am trying to help *her*," was her answer. My patient is healed and no longer has bottled up antagonisms, but we now have another ulcer candidate in the little bully.

COMMENT

One cannot deal with numbers of ulcer patients without forming definite opinions regarding factors which contribute to the formation of the lesion. The majority of our patients have at least one parent with an ulcer. In one family three siblings and both parents are affected, while another of our patients has a mother, father, maternal grandfather, maternal uncle and paternal aunt with ulcers. Males are predominant in our series. In the last 30 cases, 19 are boys and 11 are girls ranging in age from 3 to 12 years. In many of the children the onset of acute symptoms followed an upper or lower respiratory infection. Numbers of them came in with pneumonitis, tracheal bronchitis or tonsillitis, and, as the symptoms subsided, epigastric discomfort appeared. In general, these children can be described as good children with high intelligence. Most of them would be classified as superior students. They are perfectionists. Time and time again the mother will say "he wants everything just so" or "he pens everything inside." High-strung and jittery, they have strong needs for praise and appreciation as well as love. Add to this the emotional problems that are present in their environment and the fuse is lighted.

MANAGEMENT

After the lesion is demonstrated, the child and his parent are sent to the dietitian. Except in those having bleeding, a liberal ulcer regimen is given. An antispasmodic-tranquilizing compound such as a mixture of oxy-

phenonium bromide (Syrup Antrenyl), 6 oz., and reserpine (Elixir Serpasil), 1 oz., is prescribed in a dosage of 1 teaspoon, three times a day, before meals and at bedtime, with magnesium-aluminum hydroxide (Maalox), 1 teaspoon, one hour after meals, three times a day, and at bedtime. Cooperation of the teacher is sought, and it does not hurt a student's prestige to be excused to take his medicine or have some milk from a thermos in his locker.

Pain rarely lasts more than a week, and the ulcer is healed in two or three months. Parents are told about the follow-up studies at the Mayo Clinic on 44 patients whose ulcer conditions had been diagnosed when they were infants or children. These studies reveal that there appears to be a 50 per cent chance that a duodenal ulcer which begins in childhood will cause symptoms when the patient is an adolescent or adult. Emotional scars do not heal readily; one must be prepared to spend time in counseling. Those beyond our skill can be referred for family counseling or individual psychiatric help. A most important factor is to spot the ulcer-prone child and take decisive action before the ulcer forms.

SUMMARY

Ulcer-prone children can often be recognized when we know the personality of the child and the stress of emotion to which he is subject, especially if there is a familial history of ulcer. Pediatricians can give counseling to ease pressures before an ulcer forms. Suggestions for management are given.

30 South Henry Street.

ONE OF A SERIES

ROENTGEN RIDDLE

HISTORY: A 15-year-old girl complained of pain in the right lower leg for approximately six months. This was intermittent in character but was increasing steadily so that a painful limp developed. The pain was relieved by acetylsalicylic acid. There was no antecedant history of injury although she occasionally bumped her shins in gym class.

PHYSICAL EXAMINATION: Some soft tissue swelling was noted on the anterior tibial aspect of the lower leg which was not read. Point tenderness was evident near the center of the soft tissue swelling. The remainder of the examination was essentially negative and routine laboratory tests were normal.

X-RAY: The tibia in its mid portion showed considerable thickening and sclerosis of the cortex anteriorly in a fusiform outline. Within the center of this sclerotic density was a smooth rounded radiolucency, which measured approximately 1.0 cm. in diameter.

Prepared by A. M. Richter, M. D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M. D., radiologist, Department of Radiology at Milwaukee County Hospital.

DISCUSSION on page 404

Fig. 1—Rodiograph of the tibia and fibula in lateral projection.

FROM THE PROCEEDINGS OF A MEETING OF THE WISCONSIN DERMATOLOGICAL SOCIETY

Edited by STEPHAN EPSTEIN, M. D.
and RICHARD J. ROWE, M. D.

Morshfield, Wisconsin

SELECTED CASES OF DERMATITIS

DERMATOMYOSITIS

Dermatomyositis is usually thought of as a fatal disease of adults, often associated with internal malignancies. But this rare disease also occurs in children; in this case malignant tumors are not found, and the prognosis is better. About 50 per cent of juveniles afflicted with dermatomyositis survive, but almost all of them with some disability.

Case 1: Presented by Richard J. Rowe, M. D., and Dean A. Emanuel, M. D., Marshfield.

This 15-year-old white girl had been in good health until March, 1961, when she noticed an eruption on her hands and face. Within a short time her hair began to fall out, and she became weak and easily fatigued. Tenderness and swelling of her knees and proximal joints developed, her appetite decreased, she lost 25 lbs. in weight, and she ran a low-grade fever.

Her skin was dry with a slight increase in pigmentation. There were purplish plaques over her elbows, knees, and finger joints, and small crusted atrophic ulcers on some of her finger tips. The hair was sparse and lusterless. There was a papuloerythematous eruption plus telangiectasia and scarring on her face. Scattered small, round ulcers with whitish centers were present on her lower buccal mucosa and gingiva. There was swelling of her right knee and swelling and tenderness of the proximal joints of her hands. General motor function was decreased. Her right hand grip was weaker than the left, and her reflexes were generally decreased. Her blood pressure was 82/65, pulse 130, and temperature 100.2 F.

The laboratory findings were as follows:

Transaminase (SGO-T) 120
Creatinine 0.7 mg. and uric acid 4.3 mg. per 100 ml.
Syphilis test (VDRL) negative
Rh test negative. L.E. test negative
Erythrocyte sedimentation rate 70 mm. per hour
Sodium 137 mg. per 100 ml.
Chloride 99 mg. per 100 ml.
Potassium 3.8 mg. per 100 ml.
Carbon dioxide 26 mEq./l.
Globulin 2.4 gm. per 100 ml.
Albumin 2.8 gm. per 100 ml.
Hemoglobin level 11 gm. per 100 ml.
Hematocrit reading 33%.
White blood cell count 3,400 with normal differential. Platelets adequate.

X-ray films of the chest showed rather diffuse parenchymal changes throughout both lungs. There was some tendency towards a honeycomb appearance along with what appeared to be some peribronchial infiltration. X-ray films of her hands showed changes in the distal ends of all fingers consisting of smoothing and slight pointing of the tufts. No soft tissue calcifications were present.

Case 2: Presented by James J. Barrock, M. D., Milwaukee.

This is a 12-year-old white boy who developed generalized weakness in November, 1959. There was a past history of pneumonia for which he was given penicillin. This resulted in "red blotches" on his face and "blisters" on his palms. He had intermittent fever from November, 1959 to June, 1960.

Examination in June, 1960, revealed a yellow tint to the skin. His lips were dry, and scaly, and an occasional scab was present. There was a scab on his left cheek, left thumb, left forearm and telangiectasia on both cheeks.

A biopsy of the skin was not diagnostic but compatible with a diagnosis of dermatomyositis. There was no pathology in the small fragment of striated muscle included

Presented Sept. 30, 1961, at Marshfield—one of four regular meetings held each year by the Wisconsin Dermatological Society at various locations in the state.

The editors selected cases which they thought might be of interest to the general practitioner and the nondermatological specialists.

with the biopsy. The blood cell count was normal; white blood cells numbered 7,500.

The patient was placed on corticosteroid and corticotropin (ACTH) therapy. In March, 1961, the generalized weakness increased in intensity and muscle soreness was noted. With an increase in corticosteroids, he developed Cushing's syndrome.

DISCUSSION. *Dr. Louis A. Brunsting,* Rochester, Minn.: While it is true that the young man in Case 2 has a severe disabling disease, I am not at all convinced that he has dermatomyositis. I would suggest that a careful appraisal be made by a neurologist. He shows nothing on his skin. In the case of the young girl (Case 1), there is a characteristic reaction of dermatomyositis on the skin with the lesions over the acral areas, arthritis, profound muscular weakness, remarkable pulmonary infiltrative changes and roentgenologic evidence of absorption of the terminal phalanges. The serum transaminase is still elevated. The development of calcium abscesses is indicative of the later phases of the disease; this may continue intermittently for several years, even after all signs of activity have abated. The prognosis of dermatomyositis in children is better now than it has been because with the protective use of steroids, we are able to save some of those who in earlier years succumbed during the first year of illness. Few of these patients recover without some measure of disability.

GRANULOMA OF SKIN. NECROBIOSIS LIPOIDICA? TUBERCULOSIS? NOCARDIOSIS?

Necrotizing chronic granulomas present a difficult diagnostic problem. "Miescher's granuloma" is a rare and little known entity which probably is the nondiabetic counterpart of the more frequently seen and usually easily recognized necrobiosis lipoidica diabeticarum.

Case 3: Presented by Stephan Epstein, M. D., Marshfield, and Samuel L. Henke, M. D., Eau Claire.

A 66-year-old woman had an ulcer on her right leg for a period of eight years. During this time it gradually increased in size. It had been treated with various external medications. During the last two years she had received isoniazid therapy without benefit. The ulcer never healed except in May, 1961, when the patient was hospitalized for a cholecystectomy. At this time she was treated with penicillin and streptomycin. However, within three weeks the ulcer broke down again. The patient was first seen by one of the authors (S. E.) in August, 1961, with scattered ulcerated lesions on the outside of the right lower leg (Fig. 1).

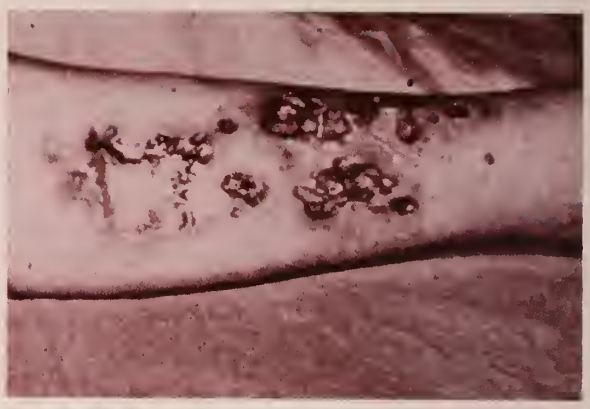


Fig. 1—Case 3. "Miescher's granuloma" (Necrobiosis lipoidica granulamotasis).

Results of the general examination were noncontributory, except that the patient had a calculus in her ureter on the right side. There was no diabetes present and none in the family.

Several biopsies performed previously and after admission showed a granulomatous infiltrate. A pathologist suggested the sections were compatible with necrobiosis lipoidica diabeticorum.

No fat stains were done because this diagnosis was suspected clinically only after the biopsies had been performed.

Culture from the surface yielded a pure culture of Pseudomonas aeruginosa, and all cultures taken during the biopsies yielded the same organism. Cultures for fungi and tubercle bacilli as well as inoculation of guinea pigs were negative. The patient was treated with prednisolone, x-ray treatments and a spray containing neomycin. (As of January, 1962, the ulcers were healed.)

DISCUSSION. *Dr. Hamilton Montgomery,* Rochester, Minn.: I think this is a definite case of necrobiosis lipoidica granulomatosis, which is the term used by Rollins and Winkelmann, or Miescher's granuloma. I made this diagnosis histologically on sections sent to me by the attending physician. The sections shown at this presentation also fit the diagnosis. There are a great many palisading granulomas. The so-called palisading granulomas with which we are concerned here, in differential diagnosis, are granuloma annulare, necrobiosis lipoidica diabeticorum, and most cases of ne-

crobiosis lipoidica without diabetes. The latter is synonymous with necrobiosis lipoidica granulomatosis, or Miescher's granuloma. As Rollins and Winkelmann have shown, the latter predominate in adult females in 90 per cent of all the cases. The lesions are limited almost exclusively to the legs, and occasionally the condition may be unilateral. The diabetic type occurs in children as well as in adults and about 57 per cent in females. In diabetic necrobiosis the lesion is larger and deeper in the cutis and one sees some obliterative changes in the vessels. In Miescher's granuloma emphasis was first placed on its similarity to sarcoid or to a form of tuberculosis and the areas of necrobiosis were interpreted by some as caseation necrosis. Frequently there is a very definite involvement of the walls of the blood vessels leading to almost complete obliteration. Within the walls of the blood vessels there is a foreign body giant cell or an epitheloid cell reaction which might explain the confusion that exists with regard to erythema induratum and sarcoidosis.

The patient in Case 3 has a deep subcutaneous involvement with all the clinical and histologic features of Miescher's granuloma.

Palisading granulomas can be seen in many other conditions, such as rheumatic and rheumatoid nodules, from deodorant granulomas to juxta articular nodes, to granuloma annulare-like lesions in tuberculoid leprosy. The phenomenon of necrobiosis or pseudonecrosis in all these granulomas remains to be explained.

PORPHYRIA CUTANEA TARDA

Porphyria, a disease with protean manifestations, now also may be linked to the collagen diseases through sclerodermoid manifestations. The question is: Are we dealing with scleroderma-like changes, or is there an association with true scleroderma?

Case 4. Presented by Richard J. Rowe, M. D., Marshfield, and David L. Walls, M. D., Madison.

A diagnosis of porphyria was first established in this 73-year-old white man in May, 1958. At that time the eruption had been present for 18 months. Later in 1958 scleroderma was noted also on his collarline. He was first seen by the authors in October, 1960.

Examination revealed a crusted, erythematous, scaling eruption involving his face, neck, ears, and upper chest. There was slight erythema and scaling of his hands. Sclerodermatous changes were present on his neck and in patches on his upper trunk. His liver was down 2 fingerbreadths. X-ray studies of the upper gastrointestinal tract revealed a normal functioning esophagus, stomach, and bulb with evidence of marked hypermotility of the intestinal tract.

LABORATORY FINDINGS. The blood count was essentially normal with the white blood cells numbering 9,300. Serum proteins, blood urea nitrogen, glucose, cholesterol, and phosphorus were within normal limits. Calcium 8.8 mg. per 100 ml. sulfobromophthalein sodium retention 18%, porphobilinogen negative, uroporphyrin 2,064, acid phosphatase 2.9 units, C-reactive protein 2+, cephalin flocculation test 3+ at 24 hours and 4+ at 48 hours, urobilinogen negative, coproporphyrin 100, uric acid 6.6 mg. per 100 ml., serum glutamic oxalopyruvic transaminase (SGO-T) 28, serum glutamic pyruvic transaminase (SGP-T) 8, L. E. test negative.

A skin biopsy was consistent with a diagnosis of scleroderma.

DISCUSSION. *Doctor Walls:* The interesting thing about this patient is not only the porphyria but the scleroderma changes. There have been several similar cases reported by French investigators. They usually speak of it as porphyria with sclerodermoid changes. I would like to raise the possibility that instead of saying this is sclerodermoid changes that this is scleroderma, and that the concomitant diseases have etiologic significance. It is known from the work of Price, Brown and Peters that there is abnormal tryptophan metabolism in both of these diseases which would tend to link them together.

Doctor Brunsting: The signs on the skin in this patient point to scleroderma although in the past there have been signs of porphyria cutanea tarda as well. We are seeing a group of patients in whom these two disorders are combined; in some of them, when the porphyria is recognized and the proper treatment is instituted, certain of the features of scleroderma may resolve. On the other hand, those changes which appear on the face and hands as a result of chronic exposure to light, remain as they are, or progress to form areas of calcinosis. This man also has widespread vitiligo, which is less common in porphyrias than is hyperpigmentation. Hirsutism is not appreciated so well in men as it is in women. Our limited

experience in the use of chelating agents in the management of patients who have had porphyria or scleroderma, or a combination of the two, has not yet been carried to the point where we are able to endorse it firmly. In the management of porphyria, the most important item is to prevent further damage to the liver by prohibiting entirely the use of alcohol and barbiturates.

CONTACT DERMATITIS

Allergic contact dermatitis is o rather simple affair when an external contactant is the main cause. But more often than is generally appreciated, other factors complicate the picture. Still the discovery and elimination of the specific allergen may be the most important part of the management.

Axillary Dermatitis with Sensitivity to "Wash 'n Wear" Clothing. Positive Patch Test To Formaldehyde

Case 5: Presented by Doctor Epstein.

This 67-year-old woman suffered from a dermatitis under both arms and on her chest; it improved when she wore plain white cotton next to her skin, although it did not clear up completely.

The patient had a similar eruption many years ago, apparently from deodorants. This time, however, she had been wearing a "wash 'n wear" blouse prior to the appearance of her dermatitis. Routine patch tests were negative, except for a repeatedly positive test to formaldehyde, which produced a persistent dry dermatitis lasting for over 10 days.

It appears that this patient fits into that goup of "axillary dermatitis" with sensitivity to formaldehyde where the original sensitivity may have been due to a formaldehyde-containing deodorant and the recurrence provoked by formaldehyde in a plastic material used for "wash 'n wear" clothing. Other irritating factors were undoubtedly present.

Contact Dermatitis from Shoes. Sensitivity to Rubber and Dichromate

Case 6. Presented by Doctor Epstein.

This 14-year-old boy had repeated attacks of dermatitis of the feet. The last one occurred shortly after wearing a new pair of work shoes. Patch tests with various rubbers, accelerators, and potassium dichromate were positive.

Dermatitis Turning into Psoriasis from Contact With Bowling Ball

Case 7. Presented by Doctor Epstein.

This 63-year-old man was first seen in February, 1961, with patches of a hyperkeratotic, fissured dermatitis on the right thumb, right little finger, middle finger, and also one on his left thumb. The location of the dermatitis on both hands corresponded perfectly to the points of contact with a bowling ball. It had begun shortly after he started bowling in September, 1960. The patient quit bowling and by the end of March the dermatitis had completely disappeared. However, there was a recurrence in May which very much resembled psoriasis. A biopsy was performed; the sections were diagnosed as psoriasis.

Patch tests with scrapings from the bowling ball as well as with formaldehyde and phenol were negative.

DISCUSSION. *Doctor Brunsting:* These are examples of cases of dermatitis in which it seems that the offending agents have been isolated. The relationship of sensitivity to formaldehyde to dermatitis of the axilla is one that is not generally appreciated. A positive patch test is not always the answer to the problem. Persons may be sensitive to chrome, nickel, rubber, or formaldehyde, which may be real enough, but which may be incidental to the overall picture.

In Case 7, the patient presents a few areas of circumscribed neurodermite on both hands. The relationship to contact with a bowling ball is probably incidental.

Doctor Montgomery: I did not think that the patient's condition in Case 7 was psoriasis, clinically. Histologically, the picture is comparable with a localized neurodermatitis simulating psoriasis. In the case presented, there was a greater degree of infiltrate than is seen in ordinary psoriasis. Furthermore, definite spongiosis was present. If this patient is shown to have psoriasis, then the lesion biopsied must most probably have been subject to secondary irritation, as the histologic picture was not that of psoriasis.

Dr. David W. Kersting, Milwaukee: I appreciated Doctor Montgomery's comments because it is important to be most careful in the clinical distinction and histologic corroboration of lichen simplex, chronic contact dermatitis, localized neurodermatitis, or a dyshidrosiform eczema of the hand

versus psoriasis. The problem too frequently revolves around the establishment of an occupational contact or traumatic dermatitis versus a nonoccupational psoriasis.

Doctor Epstein: These three cases were presented with tongue in cheek as "contact dermatitis." They should have been labeled "contact dermatitis plus!" Doctor Brunsting's comments are most pertinent. There is something more to these cases than plain contact dermatitis. The woman with the sensitivity to formaldehyde (Case 5) and the boy with the rubber sensitivity (Case 6) are both atopic (allergic) individuals. Elimination of the offending contact brought prompt improvement but did not lead to a rapid cure. In fact, the woman still has an atopic dermatitis of the axillae. Yet the revelation of these contact sensitivities is very important for the patients; only since they have been discovered and eliminated, has the dermatitis been brought under control.

The bowler's dermatitis (Case 7) may never have been a true contact dermatitis at all. It may well have originated as an irritative dermatitis at the site of friction with the bowling ball (lichen simplex chronicus) which then turned into psoriasis. When the histologic picture presents both the features of a dermatitis and psoriasis, I leave the decision to the expert dermatopathologists.

Unusual Reaction to Cement

Contact dermatitis from cement is comman. But the potient presented here represents a most unusual reaction for which no parallel has been reparted.

Case 8. Presented by Doctor Rowe.

This 66-year-old white man stated that in October, 1960, he spent 2½ hours kneeling in wet, ready-mixed concrete. After arising he noticed that the skin of both legs anteriorly showed a peculiar green color. This color gradually darkened over the next two days to a deep purple blue. He had some pain and bleeding and had difficulty in walking because of the stiffness of the skin in the involved areas. He had noted fever and chills for the two days prior to his coming to the hospital and his appetite had been poor for several days.

The patient's wife worked with him in the concrete using her bare hands. When he noticed the difficulty on his legs, his neighbor finished the project on which he had been working. Neither his neighbor nor his

Fig. 2—Case 8. Unusual reaction to cement. Note black gangrenous areas.

Fig. 3—Case 8. Same potient as in Figure 2 after debridement and skin grafts.

wife experienced any difficulty from contact with the cement.

Examination of his skin at the time of his entry to the hospital two days later, revealed a thick, black eschar extending from about 6 inches above his ankles to 3 to 4 inches above his knees in the anterior tibial area (Fig. 2). There were also necrotic areas present on his hands and a small area of dermatitis was noted on his buttock, which the patient said came from sitting on his heels.

A thorough general examination and laboratory studies revealed no other abnormalities.

A biopsy was interpreted as nonspecific alterations in the dermal connective tissue.

Two weeks later, the areas were debrided under general anesthesia. The involvement was third degree. After another week, split thickness skin grafts were applied to the involved areas (Fig. 3). The grafts now have healed over and the patient is well.

DISCUSSION. *Dr. Maurice J. Reuter,* Milwaukee: What is there in cement, besides its hygroscopic and alkaline contents, that could produce a picture like this? Within recent years cement has been shown to contain a very small amount of chrome, potassium dichromate.

About two years ago exterior of the upper six floors of a 60-year-old, 15-story stone building in which my office is located was repaired. In the process, much of the old mortar was removed creating a great deal of fine dust which seeped into the offices despite attempts to seal the windows. A crew of cleaning women was required to clean up the dust each evening. All those women who did not wear stockings developed a dermatitis of their legs, some showing evidence of a hypersensitivity reaction. Undoubtedly the dermatitis was produced by the mortar dust which contains cement.

Doctor Rowe: Doctor Walls and I spent considerable time talking to this patient. During the time he was in the hospital, debility was not found. Since the eruption ended quite sharply at his shoe tops and extended up over his patellae, we do not believe it was caused by pressure alone. His wife and neighbor were able to work in the concrete without damage to their skins. This would tend to rule out primary irritation as a cause. This leaves the possibility of an allergic reaction, but I have never seen an allergic response to cement of this severity. We have not done patch testing as yet because we did not want to chance the possibility of his losing the skin grafts as a result.

HEMANGIOMA (CAVERNOMA)

To treat or not to treat is the dilemma that confrants the physician when he is consulted about a hemangioma. It is now estoblished thot 85 per cent, or better, of these tumars disappear spontaneously by the time the child reoches the age of 5 ar 6 years; but early treatment moy be required when the hemangioma becomes destructive, especially abaut the body orifices, or even when the parents da not possess the intestinal fortitude ta watch a rapidly growing hemangioma.

Case 9. Presented by Doctor Epstein.

This 11-month-old infant has a hemangioma on her back, which was noticed at the age of six weeks. It was flat and the size of a nickel. It was treated with dry ice; the parents stated that after this therapy the hemangioma started to grow and became raised. At this time, the patient's parents are quite upset because surgery has been suggested. There is a cavernous hemangioma in the center of the back, measuring 3½ by 4 cm. with numerous grayish areas on top. The depth of the angioma is 1½ to 2 cm.

It was felt that no treatment was required, because the hemangioma seems to be involuting. The mother was told that if it should not disappear completely, surgical excision could always be performed later and would be a much easier job than now. She was also reassured that the dry ice therapy had nothing to do with the growth of the angioma. The child is presented for discussion of management.

DISCUSSION. *Dr. Marvin S. Kagen,* Appleton: The treatment of hemangiomas involves the parents as well as the child. The parents expect their child to be perfect although they are not. Seeing a defect upon their child, they feel that something they have done or thought in the past has caused this to happen. They feel that they are to blame.

The doctor must explain to the parents that their behavior and thoughts, especially during the pregnancy, were not the cause for the hemangioma.

We all know that over 90 per cent of strawberry colored and cavernous angiomas will disappear in less than five years. Nevertheless, it is often advisable to treat he-

mangiomas early rather than to wait for spontaneous healing.

With the use of a local anesthetic, the hemangioma can be easily excised at 10 years of age. This is far safer than subjecting an infant to a general anesthetic for a procedure that may prove to be unnecessary.

Doctor Brunsting: It is my opinion that this cavernous hemangioma will resolve in time without treatment.

KERATOSIS FOLLICULARIS

Dorier's diseose, keratosis follicularis, is an unusual familiol disarder with o typicol clinical picture and striking histologic feotures. Less severe cases may be mistoken for seborrheic dermatitis, but a biapsy will reveal the correct diagnosis.

Case 10: Presented by J. F. Hildebrand, M. D., Sheboygan.

This patient, a 35-year-old housewife and waitress, has had an itching skin eruption since childhood. In 1956, she developed jaundice as a result of chlorpromazine therapy. An exploratory laparotomy was performed for presumed obstructive jaundice. Following the operation the eruption spread from the shoulders over the back. During the past summer, the eruption appeared on the dorsa of the forearms and the dorsa of the lower portion of the thighs. The itching associated with the eruption has been increasing in severity over the years and is always worse in summertime. She tans readily and retains a great deal of her tan throughout the winter months. She states that she has had lesions resembling flat warts on the dorsa of her hands for as long as she can recall. There is no history of similar skin trouble in the family; she has three children without skin trouble. She has obtained partial relief of itching from trimeprazine.

DISCUSSION. *Doctor Kersting:* This is a classical example of keratosis follicularis, or Darier's disease. Doctor Hildebrand's clinical diagnosis is corroborated by the tissue examination. In my opinion, it still remains questionable whether the isolated single lesion, usually of the scalp, which is histologically identical to Darier's disease, bears any significant relationship to the diffuse and generalized Darier's disease as exemplified in this patient. These lesions, previously labeled "isolated Darier's disease," have been studied and reported recently by Szymanski under the title of "warty dyskeratoma" and by Helwig et al. under the name "dyskeratosis follicularis."

Doctor Montgomery: An acantholytic cell is a dying cell. It is undergoing lysis; it loses its prickles. The chromatin pattern in the nucleus is destroyed, and the material in the cytoplasm goes to the periphery of the cell, making a halo. In a sense, the round body (corps rounds) of Darier's disease is an acantholytic cell, but the complete histologic picture of Darier's disease is entirely different from that seen in any form of true pemphigus. An occasional acantholytic cell may be seen in other conditions, from experimentally produced eczema and even in Sneddon-Wilkinson's disease.

Doctor Hildebrand: Has anyone had experience with surgical planing in these patients?

Doctor Epstein: I have no personal experience, but Dr. Norman Orentreich of New York showed me pictures of a patient with Darier's disease who greatly benefited from dermabrasion.

LUPUS MILIARIS DISSIMENATUS FACIEI

True tuberculosis of the skin has become a rarity. Lupus miliaris dissimenatus faciei is one of the few forms of skin tuberculasis which shows caseatian necrosis.

Case 11. Presented by Doctor Kagen.

A 38-year-old white farmer developed an eruption on the face in February, 1961. It began as groups of papules and pustules on the upper lip and chin and gradually spread to the bearded area, eyelids, forehead and scalp. The pustules healed with the formation of reddish-brown scars, leaving alopecia on the scalp. The eruption had appeared in crops and had been diminishing during the past month.

A culture from the pustules for fungi was negative. Bacterial cultures showed hemophilus hemolyticus.

The chest x-ray film and urinalysis were negative. The tuberculin tests with PPD (purified protein derivative), intermediate strength, was positive.

Histopatholoically there is a tuberculoid granuloma in sections both from the active pustule and scarred area with true caseation in the center with giant cells.

The patient was started on isoniazid therapy, 100 mg., three times a day.

DISCUSSION. *Doctor Brunsting:* It would be well to secure more tissue in this case so that cultures and animal inoculations may be made in an attempt to demonstrate the organism.

POSTCRIPTUM: Doctor Kagen performed another biopsy, but no organisms could be demonstrated; inoculation of guinea pigs with material from the lesions was negative.

BLASTOMYCOSIS TREATED SUCCESSFULLY WITH AMPHOTERICIN B

Blastomycosis is a rare granulomatous fungus disease. The prognosis formerly was poor, but the advent of amphotericin B has drastically altered the situation, and many cases of blastomycosis, as well as of the other so-called deep mycosis, respond very well to this new antifungal agent.

Case 12. Presented by Doctor Epstein and George E. Magnin, M. D. Marshfield.

This 55-year-old Indian woman noticed a lump under the skin of her right side early in 1960. When she was first seen in April, 1961, there were two kidney-shaped ulcerations on the right side of the lower chest consisting of two granulomatous lesions (Fig. 4). Anteriorly there was a scar from a smaller healed lesion. Several biopsies were taken, which showed typical Blastomyces organisms in the corium and intraepidermal abscesses. Cultures were also positive for Blastomyces dermatitidis.

A complement fixation test and skin tests for blastomycosis were negative, and so was the skin test with coccidioidin. A histoplasmin skin test was positive. An x-ray film of the chest was negative.

For several weeks, the patient was given amphotericin B; but instead of the planned therapy of 2 gm., only a little more than 1 gm. could be given because of the frequent rise in the blood urea nitrogen, nausea and vomiting, and marked weakness. Two weeks after the start of treatment another biopsy was taken, while the lesions were healing. No Blastomyces organisms could be found in the section.

The skin lesions have healed completely.

DISCUSSION. *Doctor Magnin:* An individual who acquires a disseminated form of one of the deep mycoses, be it blastomycosis, coccidioidomycosis or histoplasmosis, probably has a basic defect in his defense mechanisms. This is exemplified clinically by the fact that people who have Hodgkin's

Fig. 4—Case 12. Blastomycosis.

disease, sarcoidosis, leukemia, or multiple myeloma are more prone to develop the disseminated type of the deep mycoses.

This concept is further supported by studies from the University of Miami in Florida, where it has been shown that the growth of Candida albicans is inhibited by a 5 per cent solution of normal human serum. Individuals with Hodgkin's disease, newborn infants, or patients with multiple myeloma require a greater concentration of their sera to inhibit the growth of Candida albicans.

At the present time, amphotericin B is the drug of choice for the treatment of blastomycosis, histoplasmosis, cryptococcosis, and coccidioidomycosis. It is also effective in sporotrichosis, but the iodides are much safer, cheaper, and easier to administer, and therefore preferred in this disease. Amphotericin B must be given intravenously in a solution of 5 per cent dextrose in water; the solution must be very dilute since thrombophlebitis occurs very commonly at the site of injection. The usual dose is 0.1 mg. per kg. of body weight per day. The maximum dose tolerated per day is usually 50 mg. Therapy is customarily initiated with a dose of 15 mg. per day, which is gradually increased by 5 mg. increments until the patient receives 50 mg. per day, depending upon how the drug is tolerated. In blastomycosis one should try to give a total of 2 gm. of the drug for a course.

Amphotericin B is highly toxic; it has many side effects, and the treatment of the disease is frequently limited by the patient's inability to tolerate the drug. The most common side effects are nausea and vomit-

ing, chills and fever; it is not unusual for the temperature to rise to 103 or 104 F. Allergic reactions to the drug do occur which may prohibit its further use. It also affects the blood. Anemia, thrombocytopenia and impairment of liver function are not uncommon. The most common toxic effect is on the kidneys. Albuminuria and casts in the urine occur frequently. A rising blood urea nitrogen is almost invariably associated with the administration of amphotericin B. When the blood urea nitrogen exceeds 20 mg. per 100 ml., the drug should be discontinued temporarily. Usually in a matter of two or three days the blood urea nitrogen will return to normal; it is then safe to resume therapy. It must be emphasized that this drug has not been used extensively for more than five years; and that in spite of its often dramatic effect, the question remains, "Does amphotericin B produce a remission or does it actually eradicate these organisms from the tissue?".

All patients treated with amphortericin B should be followed carefully following their course of therapy for evidences of recurrent disease. Healing of the skin lesions in a patient with blastomycosis should not make a physician confident that his patient is cured. However, the patient presented in Case 12 with only skin lesions—as far as we know—has a good chance of a permanent cure.

INFLUENZA VACCINATION RECOMMENDED

Early fall vaccination of the susceptible population against influenza is urged by the Public Health Service on recommendation of the Surgeon General's Advisory Committee on Influenza, according to the State Board of Health.

Influenza A_2, which was epidemic in the United States in 1957–1958 and 1960 seasons, has been essentially dormant for the past two seasons. Although accurate predictions based on this cyclical phenomenon are admittedly problematic, according to the Public Health Service, a comprehensive review of the available data would indicate that widespread outbreaks of influenza A_2 will occur during the coming winter season. Extensive occurrence of influenza B during 1962 makes most unlikely any significant recurrence of this type at the same time.

The specific recommendations of the Public Health Service for routine immunization include:

A. Persons of all ages who suffer from chronic debilitating diseases; e.g., cardiovascular, pulmonary, renal, or metabolic disorders.

B. Pregnant women.

C. Persons in older age groups; those over 45 and particularly those over 65 years of age.

Although the influenza virus may not be more likely to infect persons in these specified groups, the occurrence of influenza in these persons is more likely to be a life-threatening event. Influenza alone places a severe stress on cardiovascular and pulmonary function, and the frequency of bacterial complications is greatly increased in patients with chronic cardiovascular-renal and pulmonary disease.

D. DOSAGE

Adults, including all over age 13: Those not previously immunized should receive a 1.0 cc. (500 CCA units) dose subcutaneously as soon as practicable after September 1 and a second 1.0 cc. dose about two months later. The course of immunization should be completed by mid-December. Those previously immunized should receive a single dose of 1.0 cc. subcutaneously.

Children aged 6 to 12 years: Those not previously immunized should receive a 0.5 cc. (250 CCA units) dose subcutaneously as soon as practicable after September 1 and a second 0.5 cc. dose about two months later. The course of immunization should be completed by mid-December. Those previously immunized should receive a single dose of 0.5 cc. subcutaneously.

Children three months old through preschool age: Those not previously immunized should receive 0.1 to 0.2 ml. (50 to 100 CCA units) of vaccine subcutaneously on two occasions, separated by one or two weeks. A "booster" inoculation of the same strength should be given about two months later. The schedule of vaccination should be completed by mid-December. Those previously immunized should receive a single dose of 0.1 to 0.2 ml. subcutaneously. Since 20 per cent in this age group may experience a febrile reaction to the vaccine, acetylsalicylic acid (one grain per year of age) may be given every 6 hours for the first 24 hours.

If the preferred course of immunization described above is not possible, it should be noted that even a single dose of vaccine will afford significant protection; a second dose given as early as two weeks following the first will enhance this protection.

Fig. 1—Choledochal cyst filled with iodipamide (Chalografin) demonstrated at the level of the twelfth rib. The gallbladder and dilated hepatic radicals are also visualized.

Fig. 2—Demanstration of narrowing af the postbulbar portion of the barium-filled duodenum by the choledochol cyst containing iodipamide.

Fig. 3—The enlarged gollblodder moy be seen directly beneath the retractor and the choledochol cyst the darker structure immediately to its right.

Fig. 4—The incision scor four months postaperatively.

CHOLEDOCHAL CYST

A case of choledochal cyst in a 5-year-old girl was presented in the June, 1962, issue of the *Wisconsin Medical Journal* by William Merkow, M.D., Waukesha, Wisconsin. The accompanying illustrations demonstrate the surgical management of this patient.

Doctor Merkow's summary presented in the June issue follows:

A preoperative radiological diagnosis was made and successful surgical treatment carried out. The diagnosis of choledochal cyst can be made preoperatively by awareness, upper gastrointestinal contrast studies and intravenous cholecystocholangiography.

Surgical management should be directed towards establishing continuity of the cyst to the upper gastrointestinal tract either by direct choledochocystoduodenostomy or cystojejunostomy by Roux en Y principle. We used direct choledochocystoduodenostomy successfully in our patient. The procedure is simple and can be quickly accomplished. The danger of ascending cholangitis is minimal providing proper attention is given to the caliber of the anastomosis.

EMERGENCY BLOOD PROCUREMENT FOR CIVIL DEFENSE

By LOUIS E. REMILY, M.P.H.

Madison, Wisconsin

SINCE World War II the use of blood transfusions has become a major medical service. In a 1959 survey, with 136 of the 166 licensed general-surgical hospitals in Wisconsin reporting, 68 hospital blood banks collected 13,000 units of blood. The number of blood units given by 131 of those reporting during the same year was 125,000. It is logical to assume that community blood banks and American National Red Cross provided the remaining 112,000 units of whole blood to these hospitals.

However, hospital blood banks, with limited supplies, could not hope to meet demands for whole blood that in a period of a few days or weeks could require the total number of tranfusions given in one year under normal conditions. A civil defense emergency resulting from a thermonuclear attack on this country and in particular target areas in Wisconsin would, with little or no advance warning, create the need for staggering amounts of whole blood, plasma, plasma expanders and intravenous solutions.

To meet this need, qualified physicians in this field were appointed to serve on an advisory committee; and in conjunction with Civil Defense Health Service, State Board of Health, this committee prepared a plan for procurement and suggested items to be stockpiled in each emergency Blood Procurement Center.[1] The Disaster Care Committee of the State Medical Society has reviewed and approved this plan. The State Office of Civil Defense has appropriated sufficient funds to purchase enough stockpiled supplies, including plastic containers with integral donor sets, recipient sets, blood grouping serum and accessory supplies, to equip 30 centers. In addition, the Milwaukee County Civil Defense Agency has equipped 10 centers with glass bottles and all accessory supplies. These 40 centers are located in counties of 20,000 or more population outside probable blast areas (assumed target cities) and have the supplies in storage. Each center has supplies for drawing 1,100 units of whole blood or a total of 44,000 units for the 40 centers.

Wisconsin has received fifty-six 200-bed Civil Defense emergency hospitals. These facilities are stored in strategic locations throughout the state. Each Civil Defense emergency hospital also has one hundred and forty-four 690 ml. blood collecting and dispensing bottles (56 x 144), a total of 8,064 units, and seventy-two 500 ml. units of dextran injection (56 x 72) for a total of 4,032 units of plasma volume expanders.

In additional support of this capability, the State Civil Defense Health Services has in storage 19,000 units (500 ml. bottles) of polyvinylpyrrolidone (P.V.P., Macrose), a plasma volume expander, which can be used in lieu of blood or plasma in the treatment of shock. Such a substance can spare blood for cases in which it is indispensable and reduce transfusion risks (incompatibility reactions, serum hepatitis) in all cases where a plasma expander can properly be used instead of blood or plasma. It can also save lives in cases where blood will ultimately be necessary by tiding the patient over until blood can be obtained and prepared for transfusion. Each infusion bottle is equipped with a sterile disposable intravenous set complete with needle. To increase readiness capability, general-surgical hospitals located outside probable target areas will receive quantities of this supply based on bed capacity.

It is anticipated that hospitals now dependent upon the Red Cross Badger Regional Blood Center in Madison or the Milwaukee Blood Center, Inc. will have these sources of supply severed during an emergency. It is strongly recommended that such hospitals and all blood banks stock the essential items for collecting and giving whole blood, pending the availability of blood from the emergency bleeding centers. The quantity of materials presently stocked will not be sufficient and supplies will not be available from suppliers after the need is present. Keeping a three to six month stock of the necessary items on hand at all times, in most instances, will take care of this deficiency. By purchasing in this manner no additional expense need be incurred because

Mr. Remily is Director, Civil Defense Division, State Board of Health, Madison.

the materials can be utilized for normal operation on a rotating basis.

Much has been done to meet the need for whole blood and plasma substitutes. Unfortunately, many phases of the blood program are yet to be accomplished. The recruitment and training of personnel in procedures for collecting, processing, and administration of blood in a civil defense emergency must be done now.

One of the additional functions to be performed by veterinarians, dentists, and nurses under general medical supervision, *after adequate preparation and training,* in mass casualty conditions is the administration of whole blood and intravenous solutions.[2] Individual physicians are expected to assist, advise, and conduct training sessions for these professions when requested and, in general, assume leadership in the field of disaster medicine.

REFERENCES

1. Wisconsin State Board of Health: Manual for Emergency Blood Procurement. Madison, Wisconsin, September, 1958.
2. American Medical Association: Report on National Emergency Medical Care. Chicago, Ill., April 15, 1959.

SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1962 through December 31, 1962

BUREAU FOR HANDICAPPED CHILDREN—CRIPPLED CHILDREN DIVISION
MADISON 3, WISCONSIN

Location	*Date*	*Location*	*Date*
Ashland	August 15 and 16	Eau Claire	October 3 and 4
Wausau	August 21	La Crosse	October 17 and 18
Manitowoc	August 29 and 30	Chippewa Falls	October 24 and 25
Marinette	September 5	Racine	October 30 and 31
Kenosha	September 19 and 20	Rhinelander	November 7 and 8
Superior	September 27	Sheboygan	November 14 and 15

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age, who are referred by their family physician for orthopedic diagnosis and consultation. The reports of the examinations are then sent to the referring physician following the clinic.

REFERRAL FORMS: Forms for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for the individual clinic so when requesting same be sure to state approximately how many forms are needed and for which clinic or clinics. It is important that we know well in advance the number of persons desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral form will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic with the child.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 122 West Mifflin Street, Madison 3, Wisconsin.

Editor
H. F. HARDMAN, M. D., Marquette University

COMMENTS ON TREATMENT

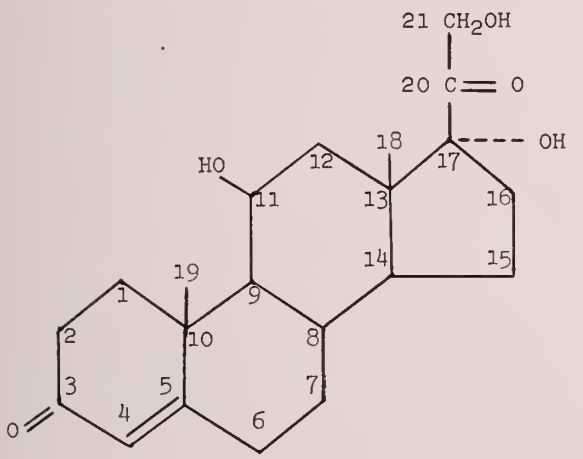
ANTI-INFLAMMATORY STEROIDS

By DEANE N. CALVERT, Ph. D.
Milwaukee, Wisconsin

RAPID development in the synthesis of steroid compounds has led to the introduction of a large number of anti-inflammatory steroids available for therapy. It is understandable that this may lead to confusion concerning the therapeutic utility of the various compounds. In a recent publication, Liddle[1] has attempted to summarize the findings concerning chemical changes which alter the therapeutic usefulness of the steroid molecule.

Because they must be employed in supraphysiological doses, the use of steroids for anti-inflammatory purposes is attended by a number of side effects. These include suppression of corticotropin (ACTH) secretion, depression of lymphoid tissue, eosinopenia, changes in central nervous system excitability, and changes in the nutrient (that is, carbohydrate, lipid and protein) metabolism and in electrolyte metabolism.

TABLE 1



Hydrocortisone (cortisol) molecule

Anti-inflammatory Activity	Salt Retaining Activity
Enhanced by	
(a) a double bond (Δ^1) between carbon #1 and carbon #2 (C-1 and C-2) (b) a fluoro on C-9, α in configuration (αF) (c) a methyl group on C-16	(a) a methyl on C-2 (b) an α fluoro on C-9 (c) a hydroxyl on C-21
Decreased By	
(a) a double bond (Δ^6) between C-6 and C-7 (b) an α hydroxyl group on C-14 (c) an α hydroxyl group on C-16	(a) an α hydroxyl on C-16 (b) a methyl on C-16 (c) a hydroxyl on C-17

The naturally occurring adrenal cortical steroids can be divided into two classes with regard to their effects on nutrient and on electrolyte metabolism. It is perhaps not surprising, therefore, that the newer synthetic compounds are also most easily divided into such categories. Table 1 presents the findings concerning structure activity relationships to date. The physician will find this information to be of value in his efforts to understand the relative anti-inflammatory and salt retaining activities of existing steroids. Whether the anti-inflamatory effects may be separated from the effects on nutrient metabolism by further chemical manipulation of the molecule is at present unknown but is under intense investigation.

Prednisolone and prednisone differ from hydrocortisone and cortisone respectively by the presence of a double bond between carbon atoms #1 and #2. This simple change enhances anti-inflammatory activity without affecting the salt retaining activity of the parent molecules. In the case of fludrocortisone (9α-fluorocortisol) the alpha fluoro substitution increases the anti-inflammatory activity eight to ten fold; however, this change is offset by a one hundred and twenty-five fold increase in sodium retaining activity.

When multiple chemical modifications are made in the basic hydrocortisone molecule, useful compounds can also be obtained. As an example, triamcinolone (Δ^1-9α-fluoro-16α-hydroxy cortisol) combines the anti-inflammatory enhancing substitution of a double bond between carbon atoms #1 and #2 and the presence of a fluorine atom on carbon atom #9. The sodium retention enhancing effect of the fluorine atom on carbon #9 is largely offset by the hydroxyl group on

carbon #16. Dexamethasone is similar to triamcinolone but has a methyl group in place of a hydroxyl group on carbon #16. The end result is that both molecules have outstanding anti-inflammatory properties with minimal sodium retaining properties.

These agents are effective when administered orally and all of them must be given around the clock to produce their maximum biological effect. Since they are all used for treatment of various collagen diseases and in a manner where hypercortical steroidism is produced, it is of interest to indicate the relative potency of these compounds when used for anti-inflammatory purposes. Giving hydrocortisone a rating of 1, cortisone is 0.7 times as effective as hydrocortisone. Prednisone and prednisolone are both 4 times more potent. Triamcinolone and methylprednisolone are 5 times as potent and dexamethasone is 30 times as potent. While they are all useful as anti-inflammatory agents, all share some of the undesirable side effects of hydrocortisone, namely, the problems with carbohydrate, protein and lipid metabolism, the corticotropin suppressing activity and the decrease in circulating levels of lymphocytes and of eosinophils. Hence, it is clear that accomplishment to date in the molecular manipulation of the steroid molecule has been a relative reduction in sodium retaining activity in the newer anti-inflammatory steroids. The removal of some of the other side effects by a similar or more extensive molecular change is still only a future hope.

REFERENCE

1. Liddle, G. W.; Clinical pharmacology of the anti-inflammatory steroids, Clin. Pharmacol. & Ther. 2: 615, 1961.

ROENTGEN RIDDLE

Continued from page 390

DISCUSSION: Osteoid osteoma, a benign bone lesion, was the roentgenographic diagnosis. The disease was first described as a probable primary bone neoplasm by Jaffe in 1935, although others were reluctant to accept this concept rather suggesting that the findings more likely represented a chronic intracortical bone abscess.

The typical clinical findings are those of increasing pain and disability of several months to two years duration in a teenage or young adult man. It has been repeatedly stated that early in the course of the disease the x-ray studies are negative. The femur and tibia are most commonly affected, although involvement of the vertebral bodies, their arches, the phalanges and the calcaneus has been reported. Interestingly, involvement of the femoral neck or ilium may produce symptoms resembling a protruded intervertebral disk. Point tenderness is a constant finding if the lesion is accessible.

Pathologically the gross specimen appears as a nidus of granulation tissue surrounded by dense sclerotic bone. Microscopically vascular fibrous tissue provides the network in which osteoid tissue and osteoblasts are found. There is no evidence of chronic inflammatory disease.

Roentgenograms are the best single diagnostic aid especially if the involvement is in the typical location. The radiographic criteria are the central radiolucent nidus, which is usually round or oval and rarely, if ever, exceeding 2 cm. in diameter. At times a bony density is seen within this nidus. This latter fact may make it difficult to detect the radiolucent nidus on routine film. Secondly there is surrounding the nidus in a fusiform pattern a thickening or widening of the cortical bone which is densely sclerotic. This surrounding cortical thickening and sclerosis is most striking in long bone involvement such as the present case and less striking if the primary lesion is found within the medullary canal of a long bone, just beneath the periosteum, or within a vertebral body. The differential diagnosis includes sclerosing nonsuppurative osteitis of Garre', but here no radiolucent nidus is evident and the cortical thickening is said to encroach into the medullary canal. Also to be considered is the chronic intracortical bone abscess of Brodie. In this situation Jaffe states that the differential diagnosis can be obtained from the clinical picture. More recent work suggests that angiography may accurately differentiate the latter lesions from osteoid osteoma. An early sclerosing osteogenic sarcoma completes the differential diagnosis. Complete surgical removal of the nidus is curative.

COMPETITION HAS REDUCED DRUG COSTS

Competition explains why antibiotics now cost about one-fifth of what they cost a decade ago, on the average. It explains why penicillin prices are now 5% of what they were after World War II. It explains why insulin costs 6% of what it cost 30 years ago; why streptomycin prices dropped 40% in less than a year; why Salk vaccine prices have been cut in half. Chemotherapy has helped bring good health to three million Americans who wouldn't be alive today if prewar rates still applied.—Edward R. Annis, M. D., in *Medical Economics*, July 17, 1961.

THE PRESIDENT'S PAGE . . .

Mutual Respect

EVERY DAY the working and practicing physicians of the United States are called upon to solve numerous and complex health problems. That they solve them well is evident to any citizen who has taken time to inform himself on the excellent health of our people. Indeed, this record is the basis of the problem of increasing numbers of senior citizens, which is so disturbing our politicians, national planners and certain pressure groups.

To arrive at a medical diagnosis, an aura of confidence must pervade. This spirit must be mutual. The doctor expects the patient to be confident of his ability to evaluate the findings pertinent to his case, and the patient expresses his trust by giving complete and honest information during the history and physical examination. In addition, both physician and patient rely on other physicians, laboratory technicians, nurses, and pharmacists to complete the diagnosis, care, and ultimately, the resolution of the illness. Thus, in an orderly and scientific manner, the stepping stones to a successful prognosis have been mutual respect and confidence.

Accustomed to this scientific approach, it is no wonder that most doctors object to an emotional or political solution to the problems of our aging population. The politicians have discovered another minority group with votes. As an educated and responsible group, interested in the welfare of the people, who are also their patients, the doctors naturally oppose this unrealistic method and seek to make their opinions heard and respected.

Contrary to current political opinion, the doctors do want the aged to have the best and proper needed care and are doing everything to arrive at that end. The welfare of the aged is the earnest concern of the doctors responsible for their care. No one can believe that the doctors would desert them now. However, their care should not be in the hands of those who say that all people over 65 are too old, too incompetent, or too deteriorated to be trusted with their own medical care. Side by side with this lack of respect for the older person goes a similar disdain of the medical profession. Delegations of practicing physicians have been *personna non grata* when they have gone to Washington at their own expense to object to present legislation. Their judgment is not respected in the field they know best, that of the physician-patient relationship. When they urge that no one, least of all government agencies, disturb this traditionally confidential rela-

(continued on page 406)

NEW BOOKLETS AVAILABLE FOR PATIENTS

HEADACHE—HOPE THROUGH RESEARCH. Explains some of the causes and types of headache, and reviews the latest treatments known to medical science. The publication also tells of the efforts medical research is making to learn the secrets behind this condition that affects man on an almost universal scale. Prepared by the National Institute of Neurological Diseases and Blindness. It is listed as Public Health Service Publication No. 905 and Health Information Series No. 104. Single free copies may be obtained from the Public Health Service. Orders under 100 are ten cents a copy from the Superintendent of Documents, Government Printing Office, Washington 25, D.C. There is a 25 per cent discount on orders of 100 or more going to one address.

ANTICOAGULANTS, YOUR PHYSICIAN AND YOU. Intended to reinforce the verbal explanation and advice given by physicians when introducing anticoagulant therapy. It explains the importance of periodic laboratory tests, warns against the possible added effects of other drugs taken without a physician's prescription, and reminds patients to mention their anticoagulant medication to other physicians or dentists from whom treatment may be sought. Copies of the leaflet may be obtained from the Wisconsin Heart Association, 205 W. Highland Ave., Milwaukee, or the American Heart Association, 44 East 23rd Street, New York 10, N.Y. Emergency Anticoagulant Identification Cards for patients to carry are also available to physicians from these sources.

WHAT EVERYONE SHOULD KNOW ABOUT ORTHOPAEDIC SURGERY. Explains how this medical specialty is helping thousands who are born with or acquire physical abnormalities. Copies may be obtained from the American Academy of Orthopaedic Surgeons, 29 East Madison Street, Chicago 2, Ill. Single copies on request—additional copies ten cents, postage paid.

WHAT CONSUMERS SHOULD KNOW ABOUT FOOD STANDARDS. Food shoppers who are interested in laws that protect their health and pocketbooks can get useful information from this new pamphlet. Issued by the Food and Drug Administration. The FDA standards regulations stand back of the quality and integrity of hundreds of major food items in the American diet. They specify what ingredients and processes may be used and the information which must be given on the label. Development of the standards is a cooperative activity on the part of Government, industry and consumers. Factual information from these sources is the basis of the standards. It is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. for 20 cents a copy.

THE PRESIDENT'S PAGE *(continued from page 405)*

tionship, they are berated and told they are obstructing progress. It is, indeed, a sad situation when neither the patient nor the doctor is trusted.

The medical profession is concerned with the care of all. The scientific methods used in a medical examination, with the mutual confidence and cooperation of all the participants, produce excellent results. If this mutual respect, combined with the scientific approach, were extended to the political aspects of the problem, a better answer to care of the aged could be formulated. Insofar as the doctors respect and have confidence in their patients and colleagues, they can, at the very least, expect the planners to respect their opinions in medical matters.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

STATESMEN NEEDED

NOW THAT President Kennedy has had his legislative nose bloodied by the defeat of his plan for tax-supported medical care, he is clearly demonstrating the political character of his proposal by promising to make it the principal issue of the November elections. Obviously the administration is promising Republican senators who combined with the "hand full" of Democrats to defeat the social security health care bill a rough time next fall.

Fortunately, the longer the administration's medical care proposals are debated the clearer become their implications. While the 17 million senior citizens constitute an impressive bloc of votes, it can be safely assumed that not all of them will be prepared to trade their common sense for a free vacation in a nursing home. Nor can the Democrats continue indefinitely to obscure the fact that their medical care program establishes a giant monopoly, which permits no choice as to participation and which lays the greatest proportion of the cost on those in the lowest income brackets.

It will be interesting to note, furthermore, how the administration will reconcile its insistence that taxes must be reduced about $9.5 billion to save the country from recession, or worse, with the fact that its medical care proposals would cost the taxpayers unknown billions of dollars.

The Kennedy administration has reacted in anger to its legislative rebuke, but most politicians will recognize the inanity of its threats of retribution. When the demagogues have gotten as much mileage as they can from their health care proposals based on taxation, it is to be hoped that they will attack the real problem, of which medical care for the aged is a facet, in a manner of statesmanship and humanitarianism.

Clearly medical care will be only one of the needs of elderly people, of whom there will undoubtedly be a relatively larger number in the next decade. The senior citizen whose resources aren't adequate to keep body and soul together will have little need for medical care no matter how easy to obtain it may be. With the changing facts of our economic life—the ever enlarging labor force, the steady lowering of retirement age, longer life expectancy, the increasing difficulty of providing for one's own security in the face of sky-rocketing taxation—the problem is to develop a condition in which the entire well being of the elderly

nonproductive person is assured, not only his medical care.

The job of our statesmen is to face up to the tremendously changed realities of our times. The political party that sets a course of sound economic policy for the entire nation can assure the total welfare of the aged as well.

The threat of political vendettas may intimidate a few, but the true representatives of the people will continue a steadfast patriotic regard for the stability and prosperity of the country, relying on the support of an enlightened electorate.—D.N.G.

WISDOM HUNTING

ATTENTION is directed to the fascinating, lively presentation of "Selected Cases of Dermatitis" that appears in this issue of the *Journal.* Culled from a meeting of the Wisconsin Dermatological Society held last fall in Marshfield, they possess qualities of authority and immediacy certain to delight the most jaded reader of medical literature.

What riches in first rate educational material go down the drain because of failure to publish is anyone's guess. The ready availability of a state journal, eager to fulfill its primary purpose of advancing medical knowledge, makes this communication deficit even more lamentable.

If nothing else, the energy expended in the production of a medical meeting warrants a record of its proceedings. With little additional effort redaction for a vastly greater audience can be accomplished. A publication such as this seems made to order for the great variety of symposia, seminars, panel discussions, case presentations, and the like, whose gems now reach the ears of only a handful of doctors fortunate enough to be physically present.

Highest commendation is due the Wisconsin Dermatological Society, its past president G. A. Cooper, and its editors Stephan Epstein and Richard J. Rowe. It is to be hoped that all of the other specialty societies in Wisconsin will emulate their splendid example.
—D.N.G.

COMMENTS FROM THE PRESS

'HERE TO TALK ABOUT INSURANCE'

Hello—I am James F. Kididdlehoffer, and I am here to talk to you about some insurance. What's that? Oh yes, my initials are the same as the president's. You say you are insurance poor—well as a matter of fact this is about government insurance and you have to take it whether you want to or not.

I know you are already paying 30 or 40 per cent of your earnings in some kind of taxes but the government says this is what you want.

If you will stop screaming, I will tell you about it. You will have to pay premiums from the day you start working as a young man, say at age 25, and pay until you are 65. No—you can't collect any benefits from 25 to 65—you just pay premiums. Sure you get some protection—the experts tell us we should live to about 72 on the average. That means you are covered for about 7 years. I know you pay for the 40 years to get seven years protection. I don't know what the policy pays but why worry about that until you are 65. No, there is no allowance for the doctor—just some benefits for the hospital.

What do you mean—this sounds like another subsidy program—hasn't every government subsidy program worked with smoothness and economy? Well, so a few people have become millionaires through subsidies—they keep the money in circulation—that's good for business.

I know it hurts when I twist your arm but sign here and quit acting like you are being hauled to the slaughter house. Remember—this is what JFK (that's me) says you want.

Okay—Okay—so write your congressman, see if I care. . .—KIDIDDLEHOFFER, Eau, Claire, Wis. (Reprinted from *The Daily Telegram,* Eau Claire, June 14, 1962)

THE MEDICAL FORUM

Menominee Health Survey Report to Council

A progress report on the first month's study of the health facilities and needs of citizens of Menominee County was presented to the Council of the State Medical Society meeting at Land O' Lakes July 27–29.

The special committee making the study is composed of five physicians appointed by the trustees of the Charitable, Educational and Scientific Foundation at their annual meeting in May. It includes:

Dr. Glen J. Steusser, Madison
Dr. Elmer P. Rohde, Galesville
Dr. Emil R. Krueger, Hayward
Dr. George Nadeau, Green Bay
Dr. Patricia F. Lanier, Kewaunee

Menominee, the state's newest county, which formerly was the Menominee Indian Reservation, comprises approximately 365 square miles in mid-northeastern Wisconsin. Upon its separation from the Federal government, the land was deeded to and is now owned by the Menominee Indians themselves—approximately 3,250 persons. The county's major villages are Neopit, site of Menominee Mills, its only industry, and Keshena, site of the old reservation government hospital, closed since May, 1961.

Committee findings showed that an operational budget for the Keshena hospital would be a minimum of $110,000 annually plus $60,000 to bring the hospital up to the minimum standards for hospital approval by the Wisconsin State Board of Health. No trained medical or nursing personnel except one county nurse exists in the county at the present time.

Shawano and Antigo hospitals are serving citizens of Memoninee with Shawano bearing the brunt of the load. Surgical-hospital insurance covers 275 persons employed by the mill; but because of the great turnover of the work force a 31-day waiting period decreases the actual percentage of insured people in the county. Approximately 50 per cent of the total population are dependent on public welfare.

Since the State Medical Society initiated the health survey last spring, the State Board of Health has done extensive mass TB testing and diagnostic diabetes detecting in the county.

Menominee county officials feel some of the health problems could be resolved if a resident physician could be obtained. The committee

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Beaver Dam Daily Citizen Photo

PARTICIPATING IN THE FORMAL DEDICATION of the Fox Lake Medical Center July 15 were (left to right) Edward J. Neitzel, president of the Fox Lake Medical Center's Board of Directors; J. T. Griffin, Chicago, president of the Sears–Roebuck Foundation; N. A. Hill, M.D., Madison, president of the State Medical Society of Wisconsin; and H. J. Kreutzmann, D.D.S., Fox Lake mayor who was master of ceremonies for the program.

Dr. Hill at Fox Lake Medical Center Dedication

Dr. N. A. Hill, president of the State Medical Society, represented the Society at the dedication ceremony of the Fox Lake Medical Center, July 15.

Commending the community on the manner in which it recognized its needs in the health care field and set out to meet them, Doctor Hill stated that the Society had been pleased to make available its physician placement service which played a part in bringing Dr. William H. Snook and Dr. J. Duxbury, both of California, to the new center.

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Approve Wisconsin Work Week of Health Plans

Plans for a Wisconsin Work Week of Health were approved by the Council of the State Medical Society at its meeting at Land O' Lakes July 27–29.

Set up in response to physicians' and the public's interest in numerous special health problems, the work week, which will be invitational to the public, will cover a wide range of topics within a concentrated period of time.

Panels will be offered under the general headings of Youth and Health, The Senior Citizen and Health, Public Health and Wisconsin, Wisconsin Industry and Health, Medical Education and Hospitals, and Interprofessional Day.

The work week will end with a conference of county society presidents and secretaries and other officers on Saturday and a special meeting of the Council on Sunday. Primary purpose of the Council meeting will be to review, analyze, and determine the future course of the work week as a result of the preceding week's program.

* * *

In other actions, the Council asked the Commission on Public Relations and Communications to prepare a statement of policy for county medical societies for use of radio and television for public information. Dr. D. E. **Dorchester**, Sturgeon Bay, is chairman of the Commission.

The State Medical Society's delegates to the American Medical Association reported on the AMA annual meeting held in June at Chicago. The delegation was represented at the Council meeting by Drs. E. L. **Bernhart** and R. E. **Galasinski** of Milwaukee. Other delegates are Dr. L. O. **Simenstad** of Osceola and Dr. A. A. **Quisling** of Madison.

Aubrey **Gates**, director of the AMA field service, addressed the Council and explained the AMA plans for its field activities and how state medical societies could assist the AMA in its efforts.

A HIGHLY POPULAR EXHIBIT at the Museum of Medical Progress in Prairie du Chien illustrates some of the medical superstitions popular through the centuries. Miss Margaret Stewart, Prairie du Chien, a guide at the museum, is shown here examining a dagger which, when placed under the pillow, would drive away all disease. The exhibit has been on loan to the museum since its opening in September of 1960 by Pitman–Moore Company of Indianapolis, Indiana.

SMS LECTURE FUND TO HONOR DR. ELVEHJEM

A $1,000 memorial lecture fund in honor of the late Dr. Conrad A. **Elvehjem** has been established by the State Medical Society of Wisconsin.

"The fund will be used to sponsor lectures in the field of the basic sciences, including biochemistry," said Dr. N. A. **Hill**, Madison, president of the society.

Doctor Elvehjem, president of the University of Wisconsin, died July 27. He was also an international authority in biochemistry.

"These lectures offer the opportunity to perpetuate his contributions to the betterment of the health of the people of Wisconsin, and it is another way in which the medical profession can show its appreciation for his deep interest in continuing medical education of the physicians."

The fund will be administered by the Medical Society's Charitable, Educational and Scientific Foundation. The lectures will be held during scientific gatherings such as the Society's annual meeting in Milwaukee or in special regional programs in other parts of the state.

STATE MEDICAL SOCIETY OF WISCONSIN

To: Mrs. Conrad A. Elvehjem

On behalf of the Council and officers of the State Medical Society meeting today, I extend their deep sympathy in the loss of your distinguished husband. He will be sorely missed by medicine both in Wisconsin and nationally, and by countless others who have benefited from his outstanding services in research, administration and education.

N. A. HILL, M. D.
President

Land O'Lakes
July 27, 1962

THE ABOVE LETTER was sent to Mrs. Elvehjem while the Council of the State Medical Society was meeting in Land O'Lakes, following the sudden and unexpected death of Conrad A. Elvehjem, president of the University of Wisconsin, on July 27, in Madison.

Doctor Hill Urges Oral Polio Vaccine Programs in Counties

Dr. N. A. Hill, Madison, president of the State Medical Society, has urged each county medical society to develop an oral polio vaccine program and pointed out that the Wisconsin Junior Chamber of Commerce has offered to assist physicians in developing community-wide oral polio vaccination programs.

His statement was made in a letter to all members on August 8.

"I urge each county society to develop the type of polio vaccine program best suited to its own area so as to provide maximum protection for the people of Wisconsin against this disease," Doctor Hill said.

The State Board of Health, acting on recommendation of a Poliomyelitis Advisory Committee, has recommended that oral vaccine be used after October 15, with continued use of the Salk vaccine up until that date.

Dr. R. M. Anderson, Cumberland, president of the Wisconsin Jaycees, in a letter to his chapter presidents, urged them to make a formal offer of their services to the local medical society.

As both Doctors Hill and Anderson pointed out, responsibility for the over-all policy of the program is a medical one, including purchase, storage and administration of the vaccine.

The Jaycees will provide assistance in the staffing and promotional aspects of the program. "We applaud their interest in serving the health of the public," Doctor Hill said.

MENOMINEE SURVEY

(continued from page 409)

pointed out that there also is a great need for education of the citizens, social adaptation and social work, realization of responsibility necessary to operate and maintain a county, acceptance of regulation and law which prior to this time has never been necessary, and realization of the necessity to pay taxes, to establish an appropriate budget, and to expand facilities and the tax base of the area.

INFLUENZA VACCINATION

The State Board of Health has outlined influenza vaccination recommendations in the scientific section of this issue of the Journal, see page 399.

News Briefs

GOVERNOR MAKES APPOINTMENTS

Dr. Peter L. Eichman, Madison, associate professor of medicine and neurology at the University of Wisconsin Medical School, is one of four new members appointed by Gov. Gaylord A. Nelson to serve a three-year term on the Wisconsin Committee for Employment of the Handicapped. Dr. Ray Piaskoski, Milwaukee, was reappointed for a three-year term on the same committee.

COACHES' CLINICS IN MADISON

Drs. F. W. Reichardt, Stevens Point; George Collentine, Jr., Milwaukee; and William Bartlett, Madison, presented two programs on medical aspects of sports at the Summer Coaches Clinics in Madison August 1 and 2. The two medical programs were arranged by the Division on School Health of the State Medical Society's Commission on State Departments.

Manitowoc County Initiates Home Nursing Care Program

An experimental rural home nursing care program in Manitowoc county, which began July 1, is the first project in the state undertaken by the State Board of Health to implement the new law on nursing home care passed in the 1961 legislative session.

The county public health department, under the new plan, is eligible to receive up to $10,000 in Federal grants annually for five years. These funds will supplement the cost of the program on a per visit basis where necessary.

Nursing care will be confined to long-term or chronic disease category of illness and may include bed baths, treatments, medication and dressings. All care and instruction is to be directed toward assisting the patient to attain and maintain his highest level of independent living.

Physicians in Manitowoc county have given their full support to the initiation of the program and a county medical advisory committee will review and establish program policies.

Nursing services are available from 8:30 a.m. to 4:30 p.m. Monday through Friday to rural Manitowoc county patients who are under a physician's care. The fee schedule is $3.00 for the first hour; 50 cents for each additional one-fourth hour and $1.50—the minimum—for a half hour or less. For those unable to pay the full fee, adjustments may be made by the nurse for part fee or free visits.

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THEODORE WIPRUD (SEATED), FORMER executive secretary of The Medical Society of Milwaukee County, and since 1938 executive secretary of the District of Columbia Medical Society, Washington, D. C., is shown admiring the bust of Aesculapius which was presented to him at a dinner in his honor at the Mayflower Hotel, Washington, last spring. Roy Ragatz (center), assistant secretary of the State Medical Society of Wisconsin, presented the bust on behalf of the State Medical Society of Wisconsin and Mr. Wiprud's many medical friends in the state. Dr. Herbert Ramsey (left), Washington, D. C., was master of ceremonies.

Mr. Wiprud is serving as special consultant to the Blue Shield health insurance program in Washington, D. C., since his retirement as executive secretary of the District medical society on July 1.

Merck Sharp & Dohme Gives to Foundation

For the second year, funds from the Merck Sharp & Dohmé Postgraduate Program are being made available to the State Medical Society through the Charitable, Educational and Scientific Foundation. A "drawing account" of $1,500 has been allocated for the Society's Speakers Service to county medical societies, and $750 has been given in partial support of the circuit teaching programs for 1962–1963.

DR. HILL AT FOX LAKE

(continued from page 409)

"This service has been successful in over 40 occasions this past year," Doctor Hill said. "I might also mention our student loan fund, with more than $80,000 on loan to medical students, which helps young men and women complete their medical education and provides future physicians for communities such as Fox Lake," he continued.

Doctor Hill also credited the Sears–Roebuck Foundation for the significant role it played in achieving the medical center.

Kennedy's Health Plan Defeated

The U. S. Senate, with all members present and voting, defeated the Administration's plan for medical care for the aged financed through Social Security. The vote was 52–48 to "table," or turn down the Administration's plan, which was offered as an amendment to a House-passed bill, providing certain reforms of the nation's public welfare laws.

Petitions distributed by the State Medical Society of Wisconsin and the Wisconsin Academy of General Practice were signed by 63,524 Wisconsin voters requesting Wisconsin Senators and Congressmen "to oppose any further government control of medical care" and favoring "free choice of my physician and voluntary insurance."

Commenting on the Senate vote, Dr. N. A. Hill, Madison, president of the State Medical Society, said: "The Senate took the proper action by rejecting President Kennedy's attempt to have the Federal government capture health care of the older people. I only wish that the junior Senator from Wisconsin had seen the tragic mistake that such legislation would be." Senator Proxmire voted for the President's bill while Senator Wiley opposed it.

Doctor Hill continued, "I hope that the people of Wisconsin will now turn their attention to passage of a Kerr–Mills Act for our state, something that should have been done a year ago. Thirty-eight states are already ahead of us in taking this more sensible approach to helping those of our elderly who actually need assistance with their health care expense."

DR. ACHESON NAMED COORDINATOR

Dr. William E. Acheson, Valders, has been named to coordinate rural health activities for the Commission on Public Relations and Communications of the State Medical Society. He has been a member of the commission since 1959.

Foundation Trustees Plan Memorial Lectures

Name Beaumont and Cunningham Lectures

Trustees of the Charitable, Educational and Scientific Foundation of the State Medical Society at their annual meeting in Milwaukee May 9 approved the establishment of memorial lectures and laid the ground rules for implementing them. The trustees then created two specific memorial lectures, one honoring Dr. William Beaumont, and the other, Dr. Wilson Cunningham.

Such lectures will commemorate a physician, a person, an event, circumstance or purpose of complete validity. The ground rules included the following decisions by the trustees: There should be assurance of sufficient financing so that no less than five such lectures in a five-consecutive-year period can be presented. Speakers will be selected by the Commission on Scientific Medicine which acts as the Scientific Committee of the Foundation. The lectures need not necessarily be held during the Annual Meeting of the Society nor be an annual event. Appropriate funds to support the lectures would be secured on an individual basis, subject to specific requirements of each lectureship.

THE WILLIAM BEAUMONT commemorative medallion was especially designed and struck for the XIII International Physiological Congress held in Boston in 1929. Maurice B. Visscher, M.D., of the Department of Physiology, University of Minnesota Medical School, donated the medallion to the Museum of Medical Progress at Prairie du Chien where Doctor Beaumont is honored. Replicas of this medallion are presented each year to the person who presents the annual Beaumont Memorial Lecture at the Annual Meeting of the State Medical Society. Thus far, two speakers have received the medallion—Drs. Burrill B. Crohn, New York, and Charles W. A. Falconer, Edinburgh, Scotland.

The Beaumont Memorial Lecture will be given at the Annual Meeting of the State Medical Society. An appropriation of $500 was voted to be set aside to assure honoraria for the next five years. The speaker will receive a Beaumont Medallion at the conclusion of the lecture. Although there have been previous Beaumont Memorial Lectures presented at the Annual Meeting, this is the first official action to establish it as an annual event under sponsorship of the Foundation.

The Cunningham Memorial Lecture will commemorate the name of Dr. Wilson Cunningham whose history in the affairs of organized medicine is one of long public service. His death on Jan. 27, 1962, ended a 60-year medical practice in Platteville. He was a past president of the Grant County Medical Society, a member of the Council of the State Medical Society for over 30 years, and served as president of the Society in 1925.

The trustees outlined specific details for instituting this lectureship. The lecture may but need not be given in association with a particular event and its topic should not be restricted. The topic should be of general interest to the public as well as to the medical profession. Choice of the topic should be determined by the Executive Committee of the Foundation.

This will be a traveling lecture, to be held for the most part in southwestern Wisconsin. Trustees indicated their preference for holding the first lecture in Platteville, but thereafter the location would be determined on the basis of the current situation.

The lecture would be supported by the income from a $2,000 grant from the State Medical Society to the Foundation. Each speaker will be given a Cunningham Medallion bearing a profile of Doctor Cunningham and inscribed as the Cunningham Memorial Lecture. Its design is being developed.

PHYSICIANS SUPPORT MARQUETTE AND U. W.

Physicians contributed $124,119.06 to Wisconsin's two medical schools in 1961. The American Medical Association has announced that $14,908.18 to Marquette University School of Medicine and $11,020.38 to the University of Wisconsin Medical School was given through the AMA Education and Research Foundation. Contributions amounting to $50,728.50 for Marquette University School of Medicine and $47,462.00 for the University of Wisconsin Medical School were made directly to the schools by the physicians.

Deans of the schools may use Foundation grants at their discretion for special projects or expenses outside of their budgets.

ELECTED A.M.A. AUXILIARY TREASURER

Mrs. C. R. Pearson, Baraboo, was installed as treasurer of the Woman's Auxiliary to the American Medical Association at its 39th annual convention in Chicago in June.

PROFESSIONAL BUSINESS SERVICE
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Inquiries Invited

Methods of Retention of Hospital Records Clarified

While there is no requirement under Wisconsin law as to the length of time for retaining the original of a patient's hospital record, it is advisable to keep the original record for at least three years after discharge or death of the patient, according to Robert B. Murphy, general counsel for the State Medical Society.

Although an accurate and durable reproduction of a record on microfilm is as fully admissible before a court as the original itself, the original is in many ways more convenient to handle and to read than microfilm, and the opportunity for physical examination of an original patient record minimizes the chance of suspicion or the assertion that something is missing.

When a patient's hospital record is microfilmed—and as a matter of law this could be done as soon as the patient was discharged or died—it is recommended that the entire *medical* portion but not the *nonmedical* portion be microfilmed, if, as a practical matter, the latter can be separated from the former.

The medical portion would include: the history, physical examination, orders, treatment, and progress notes of the physician in charge, those of all medical consultants, graphic records and nurses' notes made pursuant to standing or special orders; anesthesia and operation records. It would also include notes of a resident since he is required by Wisconsin law to be a licensed physician.

Nonmedical or "educational" portions of a patient record which need not be reproduced, include: notes of interns, unless they were made under the direction of a physician and approved by him; notes of nurses which were not made in fulfillment of standing or special orders of the physician in charge; notes of medical technicians, medical students, student nurses, practical nurses, social workers or others.

(See "An Interpretation of Chapter 301, Laws of 1959", prepared jointly by the State Medical Society of Wisconsin and the two hospital associations of this state and distributed to all Wisconsin hospitals in August, 1960.)

AMA RESOLUTION

A 1960 resolution of the House of Delegates of the American Hospital Association recommended a 10-year minimum retention period of microfilmed records and preferred a 25-year retention period for scientific purposes, but this is a matter of medical judgment and not of legal consideration. The resolution also recommended that where the original or reproduced copy is destroyed, an index, register or summary card containing basic information be retained by the hospital.

In Wisconsin, the period required to assist a former patient, or his estate, in enforcing personal injury or contract claims against others than the hospital, its staff and employees, is three years.

To assist the hospital, a member of its medical or nursing staff, or other personnel in defending against an allegation by the former patient of negligence, the period required by law for retention of original or microfilmed records would depend upon the category in which the patient fell.

If the patient is over 21 and mentally competent, the Wisconsin statutes require that he start suit for alleged negligence within three years after the alleged act.

If the patient is over 21 and mentally ill at the time of his hospitalization, or becomes so within three years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of eight years.

If the patient is a sane minor at the time of hospitalization, he must sue the hospital or others for alleged negligence by the time he reaches 22, unless his guardian did so before he came of age.

If patient records are retained to assist the hospital in collecting its bill, such claim must be enforced within six years of the time it was incurred, unless such time was extended by act of the person owing the account.

Miss Budny to Head National Medical Assistants

Miss Alice Budny, Milwaukee, will be installed as president of the American Association of Medical Assistants at its sixth annual convention in Detroit, Mich., September 29. She is a medical assistant in the offices of Drs. B. P. Churchill, Klinge Hara and Edwin H. Schalmo, Milwaukee, and was the organizer and first president of the Wisconsin State Medical Assistants Society in 1955–56.

MISS ALICE BUDNY

Miss Budny was convention chairman of the organizational meeting of the American Association of Medical Assistants in Milwaukee in 1956 and has held many offices in the national organization since that time.

DOCTOR HARDMAN HONORARY MEMBER

Dr. Harold F. Hardman, chairman of the Department of Pharmacology at Marquette University School of Medicine, Milwaukee, has been named an honorary member of the State Medical Society of Wisconsin. Doctor Hardman, who has both the Ph. D. and M. D. degrees, is co-editor of the Comments on Treatment page in the *Wisconsin Medical Journal.*

Doctor Hardman succeeded Dr. Harry Beckman as chairman of the pharmacology department at Marquette on Jan. 1, 1962, upon Doctor Beckman's retirement. He had been associate chairman since coming to the University in August, 1960.

Films for Public Programs Available at SMS

In an effort to assist county medical societies and individual physicians in planning local programs for the public, the Commission on Public Relations and Communications of the State Medical Society has compiled from a number of sources a list of films which may be ordered through the Society office.

Prior notice of two weeks is desired, since the films must be scheduled from various sources; however, they may be available on shorter notice. Some of these are listed here:

ACCIDENT PREVENTION

"On Impact"—showing how the medical profession and automobile industry are working to combat traffic fatalities. Black and white, sound, 16mm, 15 minutes.

SELECTING A PHYSICIAN

"Choosing A Doctor"—emphasizing the importance of selecting a family physician before an emergency. Black and white, sound, 16 mm, 14 minutes.

PHYSICIAN–PATIENT RELATIONSHIPS

"Even For One"—dramatizing the importance of a doctor's judgment. Black and white, sound, 16 mm, 28 minutes.

"Night Call"—portraying 24 hours in the life of a physician. Black and white, sound, 16 mm, 26 minutes.

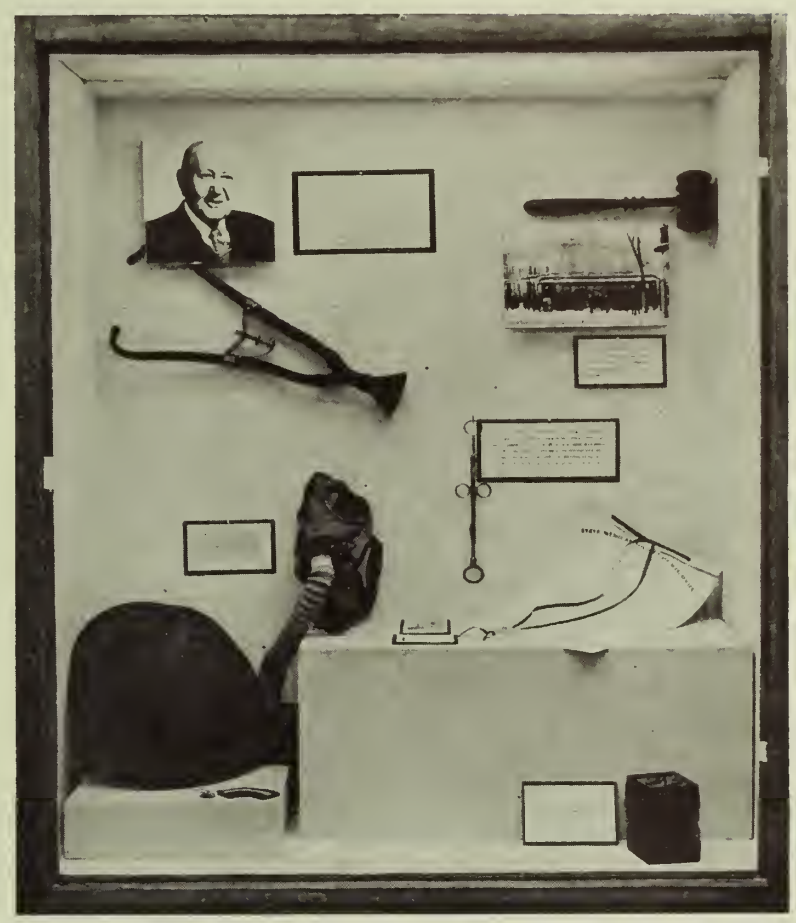
MEDICAL CAREERS

"Helping Hands For Julie"—promoting hospital careers. Black and white, sound, 16 mm, 30 minutes.

"I Am A Doctor"—a true story of a young physician who, shortly before his death from leukemia, reflected on the great satisfactions and sacrifices which medicine had brought to his life. Color, sound, 16 mm, 25 minutes.

MEDICAL SOCIETIES

"Whitehall 4–1500"—explains physicians' services to the public, as individuals and as members of medical organizations and tells how doctors as a group work to bring better medical care, health and life to all. Color, sound, 16 mm, 27 minutes.



A PIONEER WISCONSIN PHYSICIAN is honored each week in a special exhibit at the Museum of Medical Progress in Prairie du Chien. Pictured above is the display honoring Dr. F. X. Pomainville, Wisconsin Rapids. Others being honored are Dr. Cornelius Harper, Madison; Dr. James T. Reeve, Appleton; Dr. John M. Evans, Evansville; Dr. Bertha Reynolds, Avoca; Dr. Otis Hoyt, St. Croix Falls; Dr. E. B. Wolcott, Milwaukee; Dr. William E. Ground, Superior; Dr. Samuel A. Pease, Marquette County; Dr. Raymond G. Arveson, Frederic; Dr. Alfred Belitz, Pepin; and Dr. Edwin Ellis, Ashland. Each display covers the highlights in the life of the honored physician.

QUACKERY

"Mechanical Quackery"—35 mm slides with recorded narration, 33⅓ rpm, 16 minutes.

HOSPITALS

"For The Love Of Life"—portrays the hospital experience of one man who typifies all patients, and shows the variety of personnel and departments concerned directly and indirectly with his diagnosis, treatment and care. Color, sound, 16 mm, 13½ minutes.

"House of Mercy"—shows the hospital's role in the community and gives a presentation of hospital life. Black and white, sound, 16 mm, 15 minutes.

These are films with direct public relations aspects; however, there are numerous others dealing with socio-economic and medicolegal subjects available which would be of use in public programs.

For example, the American Medical Association has 89 films available for showing to nonmedical

(continued on page 416)

1963 Annual Meeting Plans

Tentative plans for the 1963 Annual Meeting of the State Medical Society were mapped out by the Commission on Scientific Medicine at a meeting July 7 at the Society headquarters in Madison. Other scientific teaching programs were also discussed.

One of the major decisions was the acceptance of a proposal for a special conference on Medical Care of the Aged to be conducted during the first full day of the Annual Meeting scheduled for Tuesday, May 7, 1963. It was agreed that the Wisconsin Society of Internal Medicine, the Wisconsin Society of Allergists, and the Wisconsin Academy of General Practice would jointly sponsor this conference in cooperation with the Division on Aging of the State Medical Society's Commission on State Departments.

Dr. A. M. **Hutter**, Fond du Lac, chairman of the Division on Aging, was instructed to formulate a specific program to include six topics: arteriosclerosis, diabetes, smoking, nutrition, arthritis, and psychiatric aspects (including the subject of "death").

Other actions of the Commission included:

STUDY ON ALCOHOLISM

1. Approved a recommendation to the Council suggesting acceptance of a special project involving a two-year study of clinical research on the subject of alcoholism. The Advisory Committee of the Wisconsin Council on Mental Health, in consultation with the Department of Public Welfare, recommended that this study be undertaken by the Wisconsin Elks inasmuch as they had expressed a desire to sponsor some project in the field of health research. The Commission further recommended that the State Medical Society appoint a physician to act as its representative in the direction of this project.

PROGRAM ON ECG INTERPRETATIONS

2. Discussed a proposal for regional conferences to provide a one-day teaching program to assist physicians, particularly generalists, in various electrocardiographic interpretations. It was suggested that these programs be scheduled in the northern half of the state, outside of the most populous regions. Dr. Richard **Wasserburger**, who is in the Department of Medicine, Cardiology Section, V.A. Hospital, Madison, outlined the proposal and offered his services in presenting the programs.

(The proposal was referred to the Wisconsin Heart Association and the Wisconsin Academy of General Practice for further consideration. It was subsequently approved with meeting sites tentatively scheduled at Dodgeville, October 18; Rhinelander or Park Falls, November 8; and Rice Lake, November 15.)

CANCER REGISTRY

3. Voted to urge appropriate groups planning the Annual Meeting programs to incorporate the matter of cancer registry as a part of their section program; specifically, the Wisconsin Surgical Society would be urged to include something on the gastrointestinal tract or the female breast, and the Section on Obstetrics and Gynecology, the uterus or ovary, or both.

4. Recommended a policy of reimbursement for the Annual Meeting be established so that guest speakers outside of the state would uniformly be accorded $50.00 plus travel, and this would also apply to "sponsored" speakers where supporting funds are made available through outside sources. (This was subsequently approved by Council action on July 28 at Land O'Lakes.)

5. Extended a vote of thanks to Dr. R. B. Larsen, Wausau, for his services on the Commission for the last five years, the maximum period of tenure. The new chairman, succeeding Doctor Larsen, is Dr. R. W. Farnsworth of Janesville.

PROGRAM PLANNERS

Members of the Scientific Committee of the Council, representatives of other specialty groups and other invited guests met with the Commission.

Those attending the meeting included: Drs. R. B. **Larsen**, Wausau; R. W. **Farnsworth**, Janesville; G. E. **Collentine** and J. S. **Hirschboeck**, Milwaukee; and V. S. **Falk**, Edgerton; representing the Commission on Scientific Medicine.

Drs. J. M. **Bell**, Marinette, and W. P. **Curran**, Antigo, representing the Scientific Committee of the Council.

Drs. John R. **Talbot** and Charles E. **Reed**, Madison; Warren K. **Simmons**, Rhinelander; and George E. **Gutmann**, Janesville; representing the Wisconsin Society of Internal Medicine.

Dr. William **Kiekhofer**, Madison, representing Obstetrics and Gynecology; Dr. Edwin L. **Bemis**, Milwaukee, Pathology; Dr. Gilbert B. **Tybring**, Madison, Psychiatry; Dr. Gerald J. **Derus**, Madison, General Practice; Dr. Stewart L. **Griggs**, Green Bay, Pediatrics; Dr. Harry E. **Thimke**, Eau Claire, Anesthesiology; Dr. William C. **Randolph**, Manitowoc, EENT; Dr. Hobart H. **Wright**, Milwaukee, Radiology; and Dr. B. Jack **Longley**, Madison, Surgery.

Others present were: Drs. W. J. **Egan** and R. R. **Watson**, Milwaukee; H. K. **Tenney** and Richard **Wasserburger**, Madison; A. M. **Hutter**, Fond du Lac.

FILMS AVAILABLE

(continued from page 415)

audiences; the State Board of Health has nearly 300. And there are numerous other sources with film listings on file at the State Medical Society.

Physicians planning a public program may write to: Public Information Department, State Medical Society, 330 East Lakeside St., Madison 1, giving information on the date of the showing, type of audience and general subject on which a film is desired. Many of the films are provided free; on others there is a cost of up to $5.00 for a showing charged by the organization distributing the film.

MICROSCOPE AVAILABLE FOR LOAN

The CES Foundation of the State Medical Society currently has one microscope available for loan to a qualified medical student. The microscope, donated to the Foundation by Dr. A. H. **Heidner** of West Bend, is at the Society headquarters in Madison. It will be loaned without charge for a reasonable period of time. Applicants should have a letter of approval from the Dean or other faculty member. Contact the CES Foundation, Box 1109, Madison 1, Wis.

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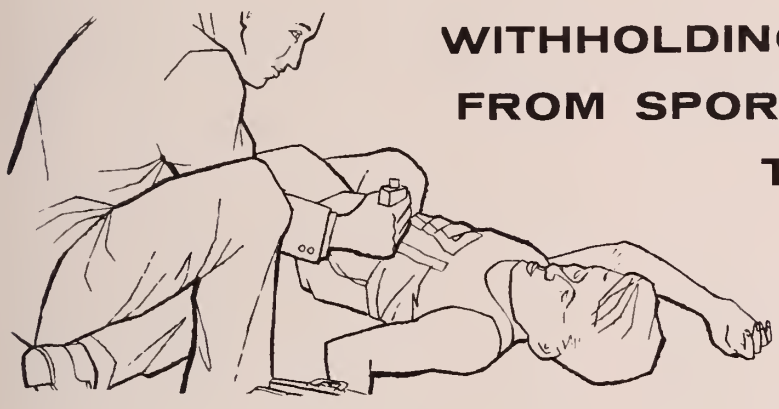

WITHHOLDING PARTICIPANTS FROM SPORTS AND RETURN TO COMPETITION

By ROBERT J. MURPHY, M. D.
Columbus, Ohio

THE PHYSICIAN responsible for high school athletes is often called upon to make the decision of withholding a boy from competition. Coaches, and at times parents, exert considerable pressure on a physician in this regard. The purpose of this presentation is to summarize some of the factors important in making these decisions. The second portion of the presentation will outline some suggestions on when a boy may return to competition after injury.

Most deaths in high school athletics are accidental, and as such are unpredictable. The actual death rate is 2.08 per 100,000 participants.[1] In 1961 there were 15 fatal injuries in 720,000 participants in high school football. Accidents also occur in automobiles, in other school activities and in sand lot activities. Deaths among those athletes participating in organized high school athletic programs are probably no greater than if these same young men were allowed to be on their own in unsupervised activities.

CONDITIONS DISQUALIFYING A BOY FROM COMPETITION

No attempt will be made here to cover all the disqualifying conditions, but those most frequently encountered will be briefly presented. Each case must be dealt with on its own merits, although there are certain guides to decisions in these areas. The sports which will be considered contact sports are football, basketball, wrestling, baseball and gymnastics. Noncontact sports include tennis, swimming, golf and track.

Maturity. A very important role that the family physician or high school team phy-

Presented at the annual meeting of the State Medical Society, Milwaukee, May 9, 1962.

Doctor Murphy is Assistant Clinical Professor of Medicine and Team Physician at Ohio State University.

sician must play is that of determining maturity of the high school athlete. The state of maturity varies greatly in adolescents of the same age. By the junior year in high school almost all boys have reached the same stage of maturation, but some sophomores and many freshmen do not reach full maturation and should be withheld from competition with boys who have. Shaffer[2] has described a deep voice, acne, facial and body hair distribution, and the character of pubic and axillary hair along with genital development as the most reliable clincal signs of maturation. It is likewise important to spot the eighth grader who is mature earlier than his classmates, in order to prevent him from injuring his classmates in pre-high school activities. Many potentially fine athletes have dropped out of competition early because of some physical or emotional trauma experienced before they reached maturation and ability to compete with boys of adult physical characteristics.

Severe Disease or Absence of One of a Paired Organ. The severe disease or absence of an eye, ear, kidney, testicle or lung is an absolute contraindication for participation in contact sports. Although the incidence of injury to these organs is quite small, the potentially serious sequela of injury to the remaining organ certainly makes this decision an easy one.

Disease of the Cardiovascular System. There seems to be a tendency on the part of some physicians to be overly conservative in advising boys with heart murmurs. Many youngsters are denied permission for participation because of a functional heart murmur. The presence of a heart murmur is not in itself an indication to deny a youngster a chance to participate in sports. Pryor[3] and others have estimated that 50 to 60 per cent of young people have functional heart murmurs at some time in their early lives. When a murmur is detected, a complete cardiac evaluation, including a history and physical examination, an electrocardiogram and cardiac fluoroscopy, is indicated. The presence of organic heart disease, especially rheumatic or congenital heart disease, is usually a reason for disqualification from sports. One death in high school football in 1961 occurred in a boy who died during football practice. It was discovered later that he had an atrial septal defect which had not been detected by previous examination.[1]

Exercise is not harmful to normal heart muscle. The so-called "athletic heart" is actually hypertrophy of the heart muscle in response to exercise. After retiring from active competition, the hearts of these athletes will usually become smaller in size.

The presence of an idiopathic auricular fibrillation not associated with organic heart disease is not disqualifying. Often premature ventricular beats will be encountered. If they disappear on exercise, they need not be disqualifying.

Direct contusion to the heart is an unusual but serious injury. One death in high school football during 1961 was attributed to direct contusion over the heart.[1] Any history of anterior chest wall contusion should be thoroughly investigated.

Hypertension in the teenager should be thoroughly evaluated to rule out coarctation of the aorta, renal disease, or other congenital abnormalities. If a blood pressure in excess of 140/90 is persistent, a thorough cardiac evaluation should be undertaken. In a highstrung emotional teenager it is not at all unusual to have an elevation of the systolic blood pressure at the time of the physician's examination.

Orthopedic Conditions. Any condition of the bone which weakens the integrity of bony function will limit, at least temporarily, participation in athletics. This includes slipped femoral epiphysis, various bone cysts, Osgood-Schlatter's disease and Legg-Perthe's disease. Infections and tumors of the bone also belong in this same category. Smith and Olix[4] have pointed out the infrequency of low back pain in the average high school athlete and suggest that any boy with persistent low back pain should be x-rayed and closely evaluated for some congenital abnormality or early rheumatoid spondylitis.

Disease of the Nervous System. Congenital or acquired diseases of the nervous system which affect the musculature will limit competition. The best prevention for injury is an adequate muscular system which can ward off trauma. Many serious injuries occur when a player is hit from the blind side, such as a block applied during a punt or kick-off return, when he is not

able to mobilize his muscular system to accept the blow. Certainly any major abnormality of the muscular system would be disqualifying from competition.

The decision of whether a boy with headaches and a previous history of head injury should participate is a difficult one. The regimen of the staff at Ohio State University for many years has been to obtain an electroencephalogram of all boys with previous severe head injuries or persistent headaches. Any boy who has sustained more than two periods of concussion in a single season is ruled out of further competition for that season and very close examination is carried out before the next season. Approximately 50 per cent of deaths in athletes are due to brain injury, and careful attention to concussion is essential.

RETURNING PARTICIPANTS TO COMPETITION

One of the most difficult decisions any physician has to make concerns when a boy should be permitted to return to competition. Obviously each case must be individualized but here are some general suggestions which may be of some value to the high school team physician.

A boy should never be permitted to play with any injury where aggravation can lead to prolonged or serious disability. On the other hand, the high school coach has the right to expect his team physician to permit his players to play with an injury when it will do no harm. If you can answer the question "Will it injure the boy to play?" in the negative, then it is a coaching decision as to whether he plays. In my opinion the team physician should not withhold a player with a painful but not serious injury because he thinks a second stringer can do better. This is a coaching decision and should be left to the coaching staff.

The use of narcotics orally, or local anesthetics directly into an injured area, is to be condemned if their use is to permit the boy to play. Nothing should be used to remove pain, the normal body defense, in any athlete.

Athletics is a particularly fertile field for the medicine man, soothsayer or drug peddler who is pushing his latest medicine or injection which will prevent bruising, hasten healing, or return the athlete to activity days quicker than normal. Patton and Patterson[6] have pointed out that healing after trauma follows a definite course. They state that "even these healthy young people involved in high school injuries require a basic minimum of time for proper healing of sprain or torn ligaments or muscle. Since we know that a fascial tear or ligament begins the fibrous phase of wound healing in three or four days and strength does not approach normal until three weeks, care and judgment must be exercised in allowing the return to competition." There is no drug to stimulate wound healing. Certain modalities are available to decrease hemorrhage and edema, and to aid normal rapid wound healing. There is nothing that can be applied, consumed or squirted on that will speed the healing process.

We must avoid over zealous treatment and be patient. There is no substitute for time and rest as a therapeutic modality.

SPECIFIC GUIDES FOR RETURN TO FUNCTION

It is the routine of our staff to treat most soft tissue injuries such as sprains of ligaments, strains of tendons or muscles, contusions of muscles or separation of cartilagenous-bone continuity in basically the same manner. This consists of the application of an ice bag for 30 to 60 minutes following an injury with elevation of the affected part. Following this, the examination of the part is more satisfactory. The area involved is often injected with 150 to 750 units of hyaluronidase and pressure applied directly over the injury. It is then wrapped with an elastic bandage and the patient told to give it complete rest for 24 to 48 hours. The patient is started on a program of heat, active exercise through pain-free range of motion, followed by active resistive exercises as the patient is able to tolerate them. If joints are filled with bloody fluid, these are generally aspirated every one to three days. Passive motion is rarely used in our therapy program. With this general regimen in mind, some of the most common injuries encountered are listed and specific suggestions on recovery of function are noted.

Knee Sprains. Injuries to the cartilage or cruciate ligaments are strictly orthopedic in treatment and should be referred to an orthopedic surgeon for surgery and/or casting. Most knee injuries involve the medial

or lateral collateral ligaments and are manifested by tenderness over the ligaments and pain when the foot is forced inward and outward with the knee in full extension. The boy is allowed to return to activity when he has full range of motion of the knee without severe pain and can lift weight with the affected knee to 75 per cent or more of the normal knee. Prior to this time, he can begin running if the knee is properly supported to prevent reinjury. The average period of disability is 10 to 21 days.

Ankle Sprain. Swelling often persists for weeks in an ankle and again the criterion to return to activity is full range of motion of the ankle with ability to lift weights equivalent to 75 per cent of the other ankle. Both ankle and knee injuries should be taped for the remainder of the season. The ankles also require 10 to 21 days for recovery.

Acromioclavicular Sprain. A sprain of this joint is popularly called a shoulder separation but rarely do we see a true separation of this joint. There is usually a partial tear. This is an injury peculiar to football and is sustained either by the player falling on his shoulder in the area of the deltoid or receiving a blow in which the shoulder is depressed and the head forced in the opposite direction. When a boy can move the shoulder in a complete range of motion without pain and can lift weights with the affected arm to 75 per cent of the other side, he can usually return to activity. It is very difficult to protect this joint by any support, such as adhesive tape, but fortunately this injury does not recur too often.

Muscle Contusion. This is a very common football injury and results from a direct blow to a muscle with a shoulder pad or helmet. Poor fitting equipment often will result in slipping of pads, allowing this type of injury to occur. A prolonged course often follows and patience is necessary in treating this particular injury. There is usually hemorrhage into the muscle sheath; and if proper early care is not taken, myositis ossificans may develop. Return to activity is permitted when full joint range of the affected muscle is possible and the patient is able to utilize the muscle, that is to run or throw without pain.

Muscle or Tendon Strain (pulled muscle). This often occurs while running and consists of pulling of the muscle or tendon fibers within the muscle sheath. The areas most commonly involved are the hamstring muscles, groin muscles and adductors of the thigh. The peroneal and posterior tibial tendons of the foot are at times also involved. Return is not permitted until full range of motion is possible and active function is pain free, but a graduated progressive resistence program is undertaken at the earliest possible moment.

Iliac Crest Bruise. Most players wear hip pads which come above the iliac crest, but with carelessly applied pads, a particularly heavy blow results in tearing of the attachment of the abdominal muscles at their attachment on the crest of the ilium. Fortunately, after return of range of motion, this injury can be protected with a pad. Although quite painful at first, it usually responds quickly, and disability is less than a week.

Brachial Plexus Stretch Injury. A stretch of the brachial plexus in the neck is usually caused by a forceful blow on the neck pushing the head to one side. The patient has pain over the plexus in the neck with weakness of the shoulder girdle and sometimes the arm. This injury has been much more prevalent since the use of the "head in" blocking techniques. Healing is slow and reinjuries are frequent. There is no good preventative taping. Two years ago we instituted a program in the off season at Ohio State University consisting of weight lifting with head and shoulders. This combined with isometric contractions of neck muscles, has measurably increased the strength of the neck muscles and cut the incidence of this injury to about one-third. We also feel that increasing the strength of the neck muscles has also decreased the head injuries.

Head Injury. It is always a difficult problem for the attending physician to determine when a boy who has a head injury in a game should be permitted to return to activity. It is important to bear in mind the safety of the player. In general, a boy who is momentarily dazed but who has prompt and complete return of sensorium is permitted to re-enter contact. A second head blow eliminates him for at least seven days.

If a boy is actually unconscious for 30 seconds or longer, he should be withdrawn from the competition for seven days and allowed to return to activity only when completely clear and free from all signs and symptoms. If a boy has the second concussion within a season, he should be barred from further competition.

Many boys will suffer a concussion but will not be unconscious. This is manifested by confusion and loss of memory. This boy should be removed immediately from competition and not returned to action until completely clear.

SUMMARY

There are few conditions which disqualify a boy from participation in athletics. This presentation summarizes some of those most frequently encountered as well as many which are not disqualifying. The return of an injured player to competition requires a basic understanding of the healing process. Specific injuries to the knee, ankle, acromioclavicular joint and muscle contusion, strain, iliac crest bruises, brachial plexus injuries and head injuries are presented.

1975 Guilford Road (21).

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LABORATORY NOTES No. 4 of a series

Protein-Bound Iodine

THE PROTEIN-BOUND iodine determination is a direct determination of the hormone of the thyroid gland.

Ingested inorganic iodine is absorbed, then selectively trapped by the thyroid gland. The ionized iodine is oxidized to the molecular form and is combined with thyroglobulin to form thyroxin and diiodothyronine. The thyroxin is normally 75 to 90 per cent of the total iodine containing material in the thyroid gland. When the serum proteins are precipitated, the thyroxin is carried down in the precipitate and its iodine is referred to as "protein-bound" iodine.

There have been many investigations designed to determine the normal ranges of the protein-bound iodine, and some doubt still exists especially as regards the lower limits of normal. The consensus is that the range is 4 to 8 micrograms per cent. The values in most laboratories are as follows:

0 to 3.9 micrograms = hypothyroidism
4.0 to 5.5 micrograms = suspicious hypothyroidism
5.6 to 8.0 micrograms = euthyroid
8.0 and over = hyperthyroidism

There is reliable data to indicate that there is a significant day-to-day variation in the protein-bound iodine (PBI) level, the variation appearing to be cyclic rather than random. The magnitude of this variation may reach 1.5 micrograms per cent.

There is no difference in the PBI of males or females. PBI of children is in the adult range after one year of age.

Increased in

1. Hyperthyroidism
2. Acute thyroiditis
3. Subacute thyroiditis (sometimes)
4. Hepatitis

Decreased in

1. Cretinism
2. Myxedema
3. Hypothyroidism
4. Chronic thyroiditis (usually)
5. Simmonds' disease
6. Nephrosis
7. Cirrhosis (may be normal)
8. Hypoproteinemia or malnutrition

All compounds containing iodine interfere with the PBI determination, but they differ in extent and duration of interference.

Compound	*Duration of Interference*
Inorganic iodine	2 to 3 weeks
Intravenous pyelogram dyes	1 to 6 months
Gallbladder dyes	12 to 18 months
Intrathecal or bronchographic dyes	1 to 5 years
Thorotrast[R]	lifetime
Hypague[R] (angiogram—59% iodine)	1 to 6 months

Prepared by S. H. Holt, M.D., Director of Laboratories, Kenosha Hospital, Kenosha, Wisconsin.

Cystadenoma of the Pancreas, Diabetes Mellitus and Splenic Involvement

By ROBERT S. BALDWIN, M. D.

Marshfield, Wisconsin

CYSTADENOMA of the pancreas is a rare tumor. Kushner and Szanto located only two instances among 10,000 postmortem examinations at Cook County Hospital.[1] Piper and associates found 20 in the files of the Mayo Clinic from 1907 to 1958.[2] Diabetes occurs in about 20 per cent of the patients. Women outnumber men eight to one. The spleen occasionally is involved and has to be removed when the tumor is excised. Two such instances were reported from Brazil among four patients with cysts of the pancreas.[3] One of these patients had diabetes mellitus. We are reporting the case of a patient with diabetes mellitus who had cystadenoma of the pancreas that was attached to the spleen.

CASE REPORT

The patient was first seen in 1954 when at the age of 74 years, he became decompensated because of arteriosclerotic heart disease. This responded well to treatment. Discovered in December, 1955, his diabetes mellitus was managed with diet alone until May, 1957, when a retropubic prostatectomy was performed because of benign hypertrophy of the prostate gland. At this time a mass in the left upper quadrant of his abdomen was considered to be the tip of the spleen. It was palpable only when he took a deep breath. Insulin up to 20 units three times per day was used during his preoperative and postoperative period. Thereafter he again managed his diabetes with diet alone until January, 1958, when tolbutamide was tried for five days without success. Then Lente insulin was used. In March, 1958, tolbutamide was given a second trial. This time it was effective.

The left upper quadrant mass increased in size and in May, 1958, the patient entered the hospital for surgical treatment. His blood pressure at this time was 120/70, temperature 98.2 F., pulse 92, weight 159½ pounds. He had a hemorrhage in the medial aspect of the right optic disc, wheezes in both lung fields, no cardiac enlargement or murmurs. A stony hard, irregular movable mass extending posteriorly was found in the left upper quadrant of the abdomen. It moved with respiration. His red blood cell and white blood cell counts and differential were normal. His hematocrit reading was 42%. A trace of sugar was present in the urine which concentrated to 1.011. Many pus cells were seen and 20 mg. of albumin was present. A fasting blood sugar was 92 mg. and his nonprotein nitrogen was 38 mg. per 100 ml. Serum albumin was 2.8 gm., globulin 3.3 gm., and the total protein was 6.1 gm. per 100 ml. A phenolsulfonphthalein test for kidney function showed 3% excretion in 15 minutes and 35.5% excretional total. Liver function tests were negative. Serum amylase was 168 Somogyi units.

A chest x-ray film, barium enema and cholecystograms were not remarkable. In the upper gastrointestinal tract x-ray displacement of the stomach anteriorly and to the left was seen. The T waves in the electrocardiogram were low throughout.

At surgery a multicystic mass involving the entire body and tail of the pancreas was found (Fig. 1). The tumor was attached to the spleen. The entire body and tail of the pancreas and the spleen were removed. The patient developed moist rales and cough productive of variable amounts of sputum. These symptoms were attributed to bronchospasm and pulmonary emphysema. Potassium iodide, antibiotics, oxygen and prednisolone 10 mg. four times a day were employed for one week. The symptoms subsided.

During the preoperative period there was no glycosuria on a diabetic diet and 1 gm. of tolbutamide daily. On the day of operation he received 15 units of regular insulin with each of three liters of 5% glucose. This was continued for the first two post-

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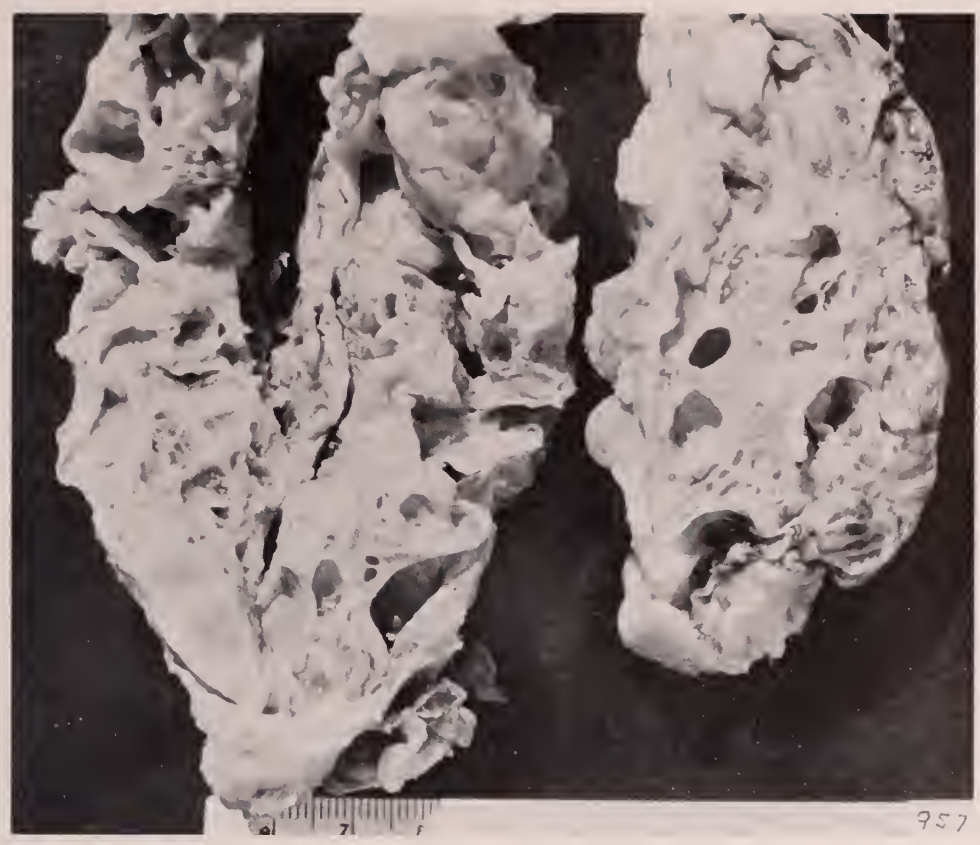

Fig. 1—Gross specimen removed ot operation.

operative days during which time his urine had 0.25% sugar on one occasion. On the third through the seventh postoperative day he received no insulin or tolbutamide and his urine tests were negative. When prednisolone was started glycosuria again appeared and was not controlled with tolbutamide. After two days Lente insulin was resumed. Fifteen units was sufficient to keep his urine test negative for sugar. This was reduced as the dose of prednisolone was decreased; and when the prednisolone was discontinued, the patient was able to maintain negative urine specimens by diet alone.

In July, 1958, his diabetes was again out of control and tolbutamide therapy unsuccessful. Lente insulin 20 units per day was started. The next month he was given phenformin (DBI) which successfully controlled his diabetes until May, 1960, when the phenformin was discontinued and tolbutamide was resumed. However, the tolbutamide therapy was unsuccessful and in July, 1960, insulin again was used. Early in September, 1960, the patient now 80 years old, entered the hospital in deep insulin shock. He had been picking hazelnuts and neglected to take his noon meal.

In October, 1960. he was well, free from symptoms, and asked for another trial on phenformin. The insulin was discontinued and 125 mg. of phenformin per day was adequate for satisfactory control. In January, 1961, he had hypoglycemic episodes. The dose of phenformin was reduced to 50 mg. per day.

The surgical specimen was reported as a normal spleen attached to the hilus of which was a cystic mass 11 by 10 by 4 cm., weighing 232 gm., containing many multilocular cysts, much fat tissue, and a thin marginal zone of pancreatic parenchyma. The microscopic appearance was predominately that of fibrous tissue and numerous cystic spaces lined by cuboidal epithelial cells (Fig. 2). A number of islets of Langerhans and some atrophic acinar cells were seen. The spleen microscopically was normal. The diagnosis was benign cystadenoma of the pancreas.

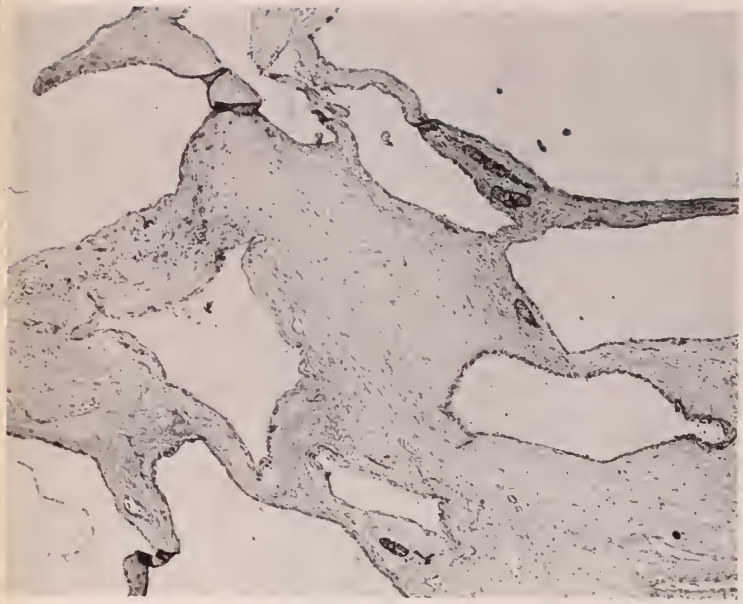

Fig. 2—Low-power microscopic section.

COMMENT

According to Glenner and Mallory[4] most of these tumors arise in the tail of the pancreas. Many of them contain islet tissue but this apparently does not secrete enough insulin to affect the patient's carbohydrate metabolism.

In our patient the course of his diabetes was not significantly altered by the presence or absence of the tumor. His insulin requirement and response to oral antidiabetic preparations was not much different during his hospital stay for the prostate operation in May, 1957, from what it was in May, 1958, and thereafter.

The high incidence of diabetes in patients with cystadenoma of the pancreas has been attributed to reduction in the number and functional capacity of the islets by pressure from the tumor.

Our patient did not find the management of his diabetes any more difficult when the tumor became larger than it was a year before. After excision of the tumor the insulin requirement was about the same as it was before.

Little has been written about these unusual tumors, which are puzzling to the pathologist. Often they are not recognized clinically or when the gross specimen is examined, but are found only when the pancreas is sectioned. They are composed of multilocular cysts lined with glandular epithelium. Most of them also contain large amounts of fibrous tissue with nests of glandular cell presumably acinar. Here and there groups of islet cells can be recognized.

The origin of the tumor is a matter of conjecture. They have been thought to rise from one or more of the following sites.[4]

1. Misplaced cells of the urogenital fold.
2. Misplaced cells of the alimentary canal, Brunner's glands of the duodenum.
3. Embryonic rests.
4. Acinar cells.
5. Duct epithelium.

Glenner and Mallory[4] believe they are duct cell adenomas. They state: "Cells of the interacinar ducts are the embryonic precursors of both the islet and acinar cells and represent potentially the most active neoplastic unit of the pancreatic parenchyma."

SUMMARY

This is the case of a 77-year-old white man who was successfully treated surgically for a 232 gm. cystadenoma of the tail of the pancreas that involved the spleen. It was necessary to remove the spleen when the tumor was excised. He also had diabetes mellitus, the course of which was not significantly altered by the presence or absence of the tumor. Cystadenomas of the pancreas contain all types of pancreatic tissue including islet cells and probably originate from duct epithelium.

650 South Central Avenue.

ACKNOWLEDGMENTS: Charles H. Bowerman, M. D., pathologist at St. Joseph's Hospital, Marshfield, made the studies of the surgical specimen. The photographs were made by Mr. A. M. Kuzma of the Department of Pathology, Marquette University School of Medicine, Milwaukee, Wisconsin.

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KIDNEY BIOPSY

By DONALD A. ROTH, M. D.
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THE INTRODUCTION of percutaneous kidney biopsy by Iverson and Brun[1] in 1951 made available a procedure which is a significant contribution to the study of renal disease. Recent large series of kidney biopsies have been reported by Kark et al.[2] and others.[3-5] The percutaneous renal biopsy has proved useful as a diagnostic aid in the evaluation of patients at Wood Veterans Administration Hospital with suspected renal disease and/or hypertension. To illustrate the diagnostic usefulness of this technique, the results of 100 consecutive renal biopsies and specific case examples are reported.

METHOD

The method of Kark[6,7] was adopted, using the Franklin modified Vim-Silverman needle with the patient in the prone position. The following prerequisites are desirable:

(a) Intravenous pyelography to locate the kidneys and demonstrate at least some concentration of the dye in both kidneys.
(b) Prothrombin concentration greater than 50 per cent.

When the patient's condition does not permit complete study, the only absolute contraindication to biopsy are single kidney, active bleeding as might be encountered in the uremic syndrome, and suspected tumor which may be amenable to surgical extirpation.

The procedure is relatively simple. The patient usually requires no sedation or prebiopsy medication, but may be given 50 mg. meperidine (Demerol) beforehand. The patient is placed in the prone position with a sandbag under the upper abdomen. After cleansing the skin with tincture of thimerosal (Merthiolate) and draping, a small area just inferior to the eleventh or twelfth rib is infiltrated with 1% procaine. The site is selected after review of the pyelograms and is usually just below the rib margin, four to six fingerbreadths from the vertebral spinous processes. The right kidney is selected, although the left may be used, recognizing the added danger of possible splenic puncture. After selecting the site, a number 20 spinal needle is inserted while the patient holds his breath in deep inspiration. The kidney may be identified by the resistance of its capsule to the needle and by the arc of the needle as the patient takes a breath. The spinal needle is withdrawn, noting its depth. The biopsy needle is inserted in the same location, depth, and direction. A small skin incision may be necessary. Care is taken not to direct the needle medially. When kidney is encountered, the stylet is removed and the cutting needle is inserted. The outer sleeve is advanced over the cutting needle, and with a twisting motion the biopsy is taken. There is usually very little bleeding, and only a small dressing is necessary. The kidney specimen is fixed in formaldehyde solution (Formalin) or Zenker's solution and processed as an ordinary surgical specimen. A culture is taken by introducing the biopsy needle containing blood and fragments of tissue into a broth tube.

The patient is kept at bed rest for 24 hours, while carefully observing pulse and blood pressure. Urine specimens are taken at the first voiding and the morning after biopsy.

COMPLICATIONS

The most serious complication was gross hematuria. This subsided promptly in three of four cases. Hematuria was persistent in one case, requiring transfusion with four units of whole blood as bleeding continued for one week. No further treatment was necessary.

Abdominal pain (one case), right flank pain (five cases) and right costovertebral and right lumbar pain (one case) were disturbing complications, but patients with these complaints all improved within 24 hours and were completely free of pain in several days.

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Microscopic hematuria was noted in 59 of 62 cases in which adequate specimens were taken and recorded. This microscopic hematuria, while listed as a complication, actually was an indication of a successful biopsy.

COMMENT

One hundred consecutive renal biopsy attempts are listed in Table 1. In only six cases was there no tissue or renal tissue inadequate for diagnosis. The 32 biopsies read as nondiagnostic were not failures. In these cases, although adequate tissue was obtained, the changes were minimal and indeed were nondiagnostic or were normal.

Sixty-two specimens were read as abnormal and a diagnosis was offered by the pathologist after study of multiple sections stained with hematoxylin and eosin and with periodic acid Schiff (PAS).

The most frequent diagnosis was arterial and/or arteriolar nephrosclerosis. In most cases this was in elderly hypertensive patients and the diagnosis was consistent with the clinical picture. The second most common tissue diagnosis was pyelonephritis (20 cases). In 13 of these 20 cases the clinical impression of pyelonephritis was listed as the reason for the biopsy. However, the clinical impression of pyelonephritis was made in 27 of the 100 cases. The failure to confirm pyelonephritis in most instances in which it was suspected is in agreement with the experience of others.[8]

In 5 cases of diabetic glomerulosclerosis, 3 were nodular and 2 were of the diffuse type. There was clinical evidence of the nephrotic syndrome in all 5.

Glomerulonephritis of all types and stages was found in only 10 cases. This reflects the low incidence of glomerulonephritis in an adult veteran population.

The diagnosis of membranous glomerulonephritis was made in 4 cases, on the basis of thickening of the glomerular capillary membrane.[9] From the clinician's standpoint, these might be termed idiopathic nephrotic syndrome. These patients presented with massive edema, hypercholesterolemia, extreme hypoalbuminemia and heavy proteinuria. There was no history of hematuria or hypertension. Attempts were made to rule out other causes of the nephrotic syndrome. The etiology of this striking syndrome in these patients remains obscure.

TABLE 1—*Summary of 100 consecutive attempts at renal biopsy*

Chronic pyelonephritis	20	
Diabetic glomerulosclerosis	5	
Nodular	3	
Diffuse	2	
Arteriolar nephrosclerosis	22	
Glomerulonephritis (all types)	10	
Membranous glomerulonephritis	4	
Interstitial fibrosis	1	62
No renal tissue	4	
Renal tissue inadequate for study	2	
Nondiagnostic renal tissue	32	38
		100

Broth cultures taken at the time of biopsy were found to contain organisms in only 6 of 87 specimens. Staphylococcus albus grew in 5 and diphtheroids in one. These probably did not represent significant infection.

USEFULNESS OF KIDNEY BIOPSY

In addition to the immediate objective of making a diagnosis, the kidney biopsy has been of benefit in other ways.

(a) Serial biopsy permits the study of the natural history of renal disease. One patient in this series had 5 kidney biopsies. Review of the progressive changes over a period of two years aided in establishing a diagnosis of membranous nephritis.

(b) Culture of the specimen at the time of biopsy has made possible the adequate treatment of certain cases of bacterial nephritis by Kark and coworkers.[10] No significant infections were discovered in this small series.

(c) Kidney biopsy may be invaluable in the selection of patients with acute renal failure for dialysis.[3]

(d) Serendipity.

Occasionally diagnoses may be established which are not suspected.

(1) In one attempt at kidney biopsy a fragment of liver tissue was obtained with the cylinder of renal tissue. After proper straining, a diagnosis of hemochromatosis of the liver was established.

(2) In a 15-year-old colored boy with microscopic hematuria, suspected of having acute glomerulonephritis, the finding of clumps of sickle cells in the

glomerular capillaries led to the correct diagnosis of sickle cell trait.

(3) A patient with hypertension and hematuria was examined by many physicians who agreed that the diagnosis was acute glomerulonephritis. Upon attempting to confirm this diagnosis with renal biopsy, an unequivocal diagnosis of acute tubular necrosis was established.

SUMMARY

Renal biopsy has been helpful in the study of 94 of 100 consecutive patients in whom it was attempted. In 62 cases, the pathologist was able to arrive at a tissue diagnosis and in 32 cases there were minimal nondiagnostic changes or no abnormalities evident. The kidney biopsy is a safe and helpful aid in the diagnosis and study of patients with renal disease.

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NATIONAL KIDNEY DISEASE FOUNDATION PUBLISHES BOOKLET WITH LATEST INFORMATION ON RENAL ILLS

An estimated 100,000 children and 500,000 men and women in the United States have an unrecognized and undiagnosed infection of the kidneys, the National Kidney Disease Foundation reports in a new booklet, "Your Kidneys—Master Chemists of the Body," which it is now distributing to the general public.

The disease, pyelonephritis, is one of the most common diseases of the kidneys and is difficult to diagnose, the booklet says. The booklet reveals, also, that 100,000 men, women and children in the United States annually die of various types of diseases of the kidneys.

The booklet is being distributed free to the general public as a public service by the National Kidney Disease Foundation and its local chapters throughout the nation. It is the first publication of its kind on the subject of the kidneys and the diseases that affect them specifically prepared for the general public, Dr. Daniel P. Richman, President of the Foundation, reported. He said that the booklet had been prepared by the Foundation's Department of Education under supervision of the Foundation's Scientific Advisory Board, made up of 21 outstanding physicians. Chairman of the Foundation's Scientific Advisory Board is Dr. Henry L. Barnett, Chairman of the Department of Pediatrics, Albert Einstein College of Medicine, New York City.

Divided into four main sections, the booklet, in its first part, discusses the importance of the kidneys to survival, their structure and function. In the second section, the various types of diseases of the kidneys are discussed, including the more common disorders such as pyelonephritis, glomerulonephritis, kidney stones, polycystic kidneys, nephrosis, acute kidney failure and uremia.

Therapies of diseases of the kidneys are discussed in the third section, which contains a discussion of kidney transplantation and the artificial kidney. A final section summarizes important points for the laymen to remember about maintaining kidney health and a chart listing diseases of the kidneys.

Doctor Richman said that the preparation and distribution of the booklet is part of the Foundation's continuing effort to arouse the public to the need for good kidney health. Other publications discussing other aspects of diseases of the kidneys will be published in the future, he said. The Foundation makes available films and other visual aids to the general public as part of its public education program.

The Foundation also provides the following services: Steroid Drug Bank Programs—nationally and locally—to provide vitally needed medication to kidney disease patients, at cost, upon recommendation of a physician; support of renal clinics, research and professional education programs.

The National Kidney Disease Foundation (143 East 35 Street, New York 16, N. Y.) is the only national health agency primarily and uniquely concerned with problems of the kidneys and the care of patients with diseases of the kidneys.

Grade A Pasteurized Milk—The Best

IN THIS LAND of plenty we sometimes take for granted many of the wonderful things about us which are actually essential for good everyday living. Milk is an example. School children can recite that it is an essential food of the baby, the sick, the aged and the infirm. They know that it is a food product which is easily digestible and contains practically all of the necessary elements to sustain life. Unfortunately, they and often their parents are not as well informed as they need to be about what precautions must be taken to safeguard milk or about the dangers in using a product which does not meet the Grade A standard of quality.

With all its wonderful attributes as a nearly perfect food, milk can also be the medium for undesirable bacteria which may have had their origin in animal or man. It is true that outbreaks of milk-borne disease in Wisconsin have been practically nonexistent in the past 20 years. This is a tribute to the fine work of groups such as our state and local health departments, the Department of Agriculture, College of Agriculture, city councils and the legislature, along with producer and processor organizations who have worked together in the Grade A milk and animal health programs. This fine record will continue only as long as everyone, including the consumer, remains vigilant.

Just 18 years ago, only one Wisconsin city had adopted regulations requiring Grade A pasteurized milk. Today, it is required in all areas and is available to every citizen in the state. Along with this program, cottage cheese is being graded in many Wisconsin communities and is becoming popular with consumers both within the state and in out-of-state markets. The grading of nonfat solids which are promoted for beverage purposes in the consumer-size package is not far distant.

With such a rosy picture before us, it would be very easy to sit back and say, "That's done." But such is not the case in the field of milk sanitation at least.

While maintaining the progress that has been made, we must continually be alert to new developments which may affect man's environment, including the food he eats and the milk he uses. The promulgation of regulations does not rule out the possibility of future outbreaks of disease or even individual cases where the proper sequence of events can set the stage for disease transmission. There is always the possibility that one animal may become infected after a clean herd has been established through a fine animal health program. Or an animal may develop mastitis which is not immediately apparent to the observer who has no way of knowing that staphylococci or other organisms are causing an infection. This could in turn infect the consumer of the milk or milk product even if the milk is properly handled. Such mastitis in dairy herds is a real problem facing dairymen today and one which requires positive cooperation by all interested parties before an effective control program can be established.

Another development, perhaps the result of complacency on the part of health personnel in not maintaining the education of the public, is the increasing purchase of raw milk by consumers who try to save a little money by driving out of town to buy from a farmer friend or relative. Of course, such action breaks the well-designed protective chain set up for producer and consumer alike. This protective chain comprises the Grade A program which includes every practical known measure to guarantee the safety of milk for the consumer. It requires sanitary milk handling at every step, from the healthy cows to the consumer, and assures the positive safeguard of pasteurization, which even today is the only practical known measure to protect a milk supply adequately. A positive system of supervision is exercised over each supply by either a local health department or the Department of Agriculture. As an additional safeguard, the State Board of Health has the responsibility for surveying and certifying, through a national evaluation program, that such enforcement procedures are effective.

An abundance of good, Grade A pasteurized milk is available—a fact which still needs repetition along with an explanation of what the Grade A label means in terms of disease prevention. This can be effectively taught and retaught by the continued support and cooperation of the family physician and the pediatrician who, instead of the simple injunction to "drink milk," can say "drink Grade A pasteurized milk," and can clarify the importance of this for his patients.—CLARENCE K. LUCHTERHAND, Chief, Milk Certification Unit, Section on Sanitary Engineering, State Board of Health, Madison.

DISEASE ERADICATION BY COOPERATION

With the introduction of the sulfonamides and the antibiotics, much security developed in the profession's and in the public's mind. Prior to the antimicrobial era, about 50 per cent of all deaths were due to or associated with infection. Probably syphilis, gonorrhea, and tuberculosis could be eradicated with universal cooperation.—H. CLOSE HESSELTINE, M.D., in *Trustee*, April 1962.

Editor
H. F. HARDMAN, M. D., Marquette University

COMMENTS ON TREATMENT

Newer Agents Which Inhibit Sympathetic Nerve Activity

By BERT K. B. LUM, M. D., Ph. D.
Milwaukee, Wiscansin

THE PHYSICIAN can interfere with the activity of the sympathetic nervous system in several ways by the use of drugs having distinctly different mechanisms of action. These include: (1) adrenergic blocking agents such as phenoxybenzamine, tolazoline, phentolamine, etc. which block the responses of effector cells to norepinephrine, the transmitter substance released from sympathetic adrenergic nerve endings; (2) ganglionic blocking agents such as mecamylamine, pentolinium, chlorisondamine, etc. which interrupt transmission across autonomic ganglia; (3) the veratrum alkaloids which activate afferent nerve impulses to effect a reflex inhibition of the medullary sympathetic centers; (4) the dihydrogenated ergot alkaloids which in therapeutic doses act by a depression of the vasomotor center; (5) reserpine and related drugs which deplete sympathetic nerve endings of their store of the transmitter substance.

Recently, a new class of drugs which inhibit sympathetic activity by a mechanism uniquely different from those described above, has been introduced as antihypertensive agents. These agents appear to act by preventing the release of the transmitter from sympathetic nerve endings. The actions of three members of this class of drugs, which have been variously referred to as sympatholytic, adrenergic neurone blocking, antiadrenergic, and sympathetic nerve blocking agents, will be described.

The site of action of xylocholine (TM 10), the classic member of this class of drugs, was established by Exley in 1957.[1] In animals, xylocholine produced a prolonged inhibition of the responses of a variety of effector organs to sympathetic but not parasympathetic nerve stimulation. Except transiently, there was no blockade of the responses to epinephrine and norepinephrine, or the transmission of nerve impulses across autonomic ganglia and along sympathetic trunks. The release of norepinephrine upon splenic nerve stimulation was markedly reduced by the drug. Results such as these thus established that xylocholine interfered with the release of the transmitter substance from sympathetic nerve endings and localized the site of action as being close to or at the nerve terminals. The precise mode of this effect on nerve endings, however, has not been clearly defined. Xylocholine has been reported to inhibit the biosynthesis of norepinephrine from its precursor, dopamine.[2] However, a loss of stores of the transmitter substance as a result of biosynthetic impairment does not account for the sympathetic block produced by the drug.[3] It is therefore not possible to relate sympathetic inhibition to interference of transmitter biosynthesis unless release of the transmitter is somehow dependent upon a continuous synthesis of the substance.

Xylocholine lacks specificity in that it has a number of other types of actions including prominent parasympathomimetic effects. Side effects referable to the latter have precluded the successful use of the drug in the treatment of hypertension.

Bretylium, which chemically is closely related to xylocholine, is the product of a search for agents having a greater specificity of action than the latter. Experimental studies, similar to those performed on xylocholine, have established that bretylium also acts on nerve terminals to prevent the release of norepinephrine.[4] The local anesthetic action of the drug and its relatively selective accumulation in sympathetic nerves and ganglia have led Boura *et al.*[5] to suggest that the sympathetic block is due to a local anesthetic action of bretylium on the fine nerve endings. However, a comparison of the actions of procaine and bretylium has led Boyd *et al.*[6] to doubt this as a mode of sympathetic block produced by the latter.

In contrast to xylocholine, bretylium has no parasympathomimetic actions and has been widely tried in Great Britain as an antihypertensive agent. However, the drug

has been found to be disappointing in the long-term management of hypertension because of the variability of its hypotensive action and the rapid development of tolerance.[7]

Guanethidine is another member of this novel class of drugs which interferes with the release of the sympathetic transmitter.[8] As with the other two agents, the precise mode of action of this agent on nerve endings is not known. In animals, guanethidine depletes sympathetic nerve endings of their stores of the transmitter as indicated by the findings that the drug produces a slow and progressive decline in the catecholamine content of various tissues.[9] In the chronic clinical use of the drug, this is probably an important aspect of its antihypertensive action. However, depletion of catecholamines does not fully account for the sympathetic inhibition produced by guanethidine since the onset of sympathetic blockade is rapid and occurs prior to any significant loss of catecholamines in tissues.[10]

The clinical reports on the use of guanethidine as an antihypertensive agent have been encouraging, although most studies have involved relatively small numbers of patients over a short period of time. The drug appears to be as potent as the ganglionic blocking agents and tolerance has not been encountered. Guanethidine has a long duration of action and its hypotensive effect may last 7 to 21 days after cessation of medication.[11] The drug therefore has a cumulative action, and initial therapy in ambulatory patients should be carefully titrated beginning with small inital daily doses followed by weekly increments until a satisfactory response is obtained.[12]

The fall in blood pressure produced by guanethidine is associated with a decrease in cardiac output without a significant change in total peripheral resistance, the reduction in output being attributed to interruption of sympathetic activity to veins and hence peripheral pooling of blood.[11] When administered acutely by the intravenous route, a pressor response may be observed in normotensive and hypertensive individuals. This appears to be due to an initial acute release of myocardial tissue catecholamines by the drug.[13]

Fewer and relatively mild side effects attend the use of guanethidine in comparison to ganglionic blocking agents due to the specificity of the former in inhibiting sympathetic but not parasympathetic activity. The side reactions to guanethidine for the most part are due to sympathetic inhibition with a consequent imbalance of autonomic activity in favor of the parasympathetic system. The most common untoward effect is diarrhea which can usually be controlled by atropine and other cholinergic blocking agents or by paregoric. Orthostatic hypotension is common but this probably should be considered to be an extension of its therapeutic action rather than a side effect. Other undesirable effects which may occur include water retention and edema (which can be relieved with diuretic agents), bradycardia, weakness, failure of ejaculation in males and nasal stuffiness.

Present clinical reports indicate that guanethidine will prove to be highly useful in the management of hypertension, especially the more severe grades of the disease.

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State Medical Society of Wisconsin

CLINICOPATHOLOGIC CONFERENCE

Guest Editor: S. H. HOLT, M. D.
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CASE PRESENTATION*

Dr. Ralph Burnett (generalist): This 35-year-old white man entered the hospital August 16, 1960, with a history of intermittent fever, tiredness, and pain for a period of two months prior to hospitalization. The pain was located in the right sacroiliac area and had been tolerable until approximately 48 hours prior to admission when it became so severe that he was no longer able to work. The patient stated that the pain had been present for approximately two months but would be relieved or actually disappear upon lying down. The pain was worse on sitting and more severe on standing. Two days prior to his admission the pain became so severe that he became bedfast and he had a high spiking fever for no apparent reason. The pain was not relieved by salicylates.

Late in June, 1960, this patient had been seen because of pain in the right anterior chest which had occurred after lifting a heavy object. There was tenderness on palpation of the right side of the chest anteriorly and associated pain upon inspiration. The pain was located at the third rib anteriorly. A chest x-ray film failed to reveal any pathology. The chest was taped for purposes of immobilization. The patient stated that the pain decreased but persisted in the same area since its onset.

Father and mother of the patient are living; both have heart disease. He has one brother, living and well.

The patient worked at a local factory where his job consisted of dipping metal into a solution. The fumes of this solution appeared to be irritating to the mucous membrane and the solution itself would eat through leather of shoes if dropped upon them.

The patient smoked approximately one package of cigarettes per day. There was no excessive alcoholic intake. The patient denied the use of drugs.

*From Kenosha Hospital.

Review of System. Only the positive responses elicited are listed.

Occasional slight epistaxis. Frequent sore throats. Weight constant. "Chronically tired and without pep." Chest pain as noted in history of present illness.

Physical Examination. The patient was a 35-year-old white man who was well developed and well nourished. The pulse rate was 80 and regular. Respiratory rate was 12 and regular. Blood pressure was 124/60. While lying comfortably in bed, the patient was alert and cooperative. The skin was clear except for a few petechiae over the neck on both sides. Examination of the eyes, ears, nose and throat was unremarkable.

The thorax was symmetrical and the anteroposterior diameter was normal. Respiratory excursions were adequate and equal bilaterally. There was marked tenderness on slight pressure over the sternum at the level of the third rib. The heart and lungs revealed nothing of note except for a few subcrepitant rales in the right base posteriorly.

The liver was questionably palpable at the inferior costal margin and there seemed to be some tenderness on palpation. The spleen was not palpated. The genitalia and rectum were reported as normal.

There were a few enlarged lymph nodes in the left axilla, measuring approximately 1 to 1–½ cm. in greatest dimension.

Marked tenderness was elicited over the left sciatic notch, sacral notch and sacroiliac joints. Lasegue's sign was negative.

Deep tendon reflexes were equal and active bilaterally and pathological reflexes were elicited.

Admission Laboratory Studies. Admission x-ray films of chest, dorsal and lumbar spines failed to reveal the presence of any demonstrable pathology in the lungs, bones or joints examined. Hematocrit reading was 23.5%, hemoglobin 8.1 gm. per 100 ml., white

blood cell count 6,250, differential—myelocytes 2, metamyelocytes 10, stab forms 11, segmented cells 32, lymphocytes 42, monocytes 3. There was a slight anisocytosis and poikilocytosis. Microcytes and target cells were present. There was increased polychromatophilia. There were 5 nucleated red blood cells per 100 cells. Platelets appeared somewhat decreased. C-reactive protein was 4+, Rh factor was negative. Urinalysis showed normal concentration, slight trace of albumin; sugar and ketone bodies were negative. Microscopic examination was within normal limits. Uric acid was 3.7 mg. per 100 ml. Throat culture showed the presence of pneumococcus, alpha streptococci, nonhemolytic staphylococci, diphtheroid bacilli, and members of the Neisseria group. The test for syphilis was nonreactive.

A repeat hematological examination on Aug. 18, 1960, revealed a red blood cell count of 1.56 million, hematocrit reading 19.5%, hemoglobin 6.7 gm. per 100 ml. and white blood cell count of 5,000. The differential count showed 2 progranulocytes, 4 myelocytes, 5 metamyelocytes, 14 stab forms, 19 segmented cells, 55 lymphocytes and 1 monocyte. The red blood cell morphology was the same. There were 11 nucleated red blood cells per 100 cells. The platelets were decreased with a count of 58,000 by the Rees-Ecker method. Stool examination was positive for occult blood. Bilirubin showed 1 minute direct 0.11 mg. with a total of 0.3 mg. per 100 ml. Alkaline phosphatase was 1.6 Bodansky units. The patient received a total of 15 blood transfusions between August 23 and November 3. His death occurred on Nov. 9, 1960.

PROTOCOL

Dr. William A. Mudge (internist): In most presentations there are bits of information which of necessity have to be deleted in order to make the case a challenge. I would presume the same exists here. In brief review, this is a case of a 35-year-old white man who was admitted to the hospital with intermittent fever, tiredness, and pain over a period of two months. The pain was located in the right sacroiliac area and was tolerated until about 48 hours prior to admission. He also had had pain in the sternal area on the right side in the region of the third rib. He was a factory worker and his job consisted of dipping metal into an acid solution. There was no excessive alcoholic intake. Physical findings were noted to be within normal limits except for the areas of pain as noted previously. Examination of the chest revealed a few rales in the right base and the liver was noted to be questionably enlarged. There were a few palpable nodes in the left axilla. They were not of significant size. In summarizing the physical findings of possible significance, we have the axillary nodes, the possible liver enlargement, and the tenderness.

In scanning the laboratory information, the most prominent abnormality was the severe anemia with a hematocrit reading of 23.5% and a hemoglobin of 8.1 gm. per 100 ml. The white blood cell count was normal at 6,250. The differential suggested some abnormality in that there were a number of immature forms present. There was slight anisocytosis and poikilocytosis, and 5 nucleated red blood cells per 100 cells were noted. The platelets were somewhat decreased. One would presume from the available information that this would be a normocytic anemia.

In attempting to make an analytical approach of our problem, it would seem that if we could explain the reason for this man's severe anemia we would, in all probability, have a solution to our problem. We must also take into consideration the bone pain and perhaps the axillary nodes, which may or may not be of significance. The age, 35 years, is of interest, and perhaps it would be helpful to know his genetic origin, race, or from what part of the world his family originated.

Approaching this case from the hematological aspect, we will first consider the major types of anemias. These consist of: first, pernicious anemia, and the related macrocytic anemias, normocytic anemias, normocytic hemolytic anemias, and hypochromic microcytic (iron-deficiency) anemia. Some of the macrocytic anemias include: pernicious anemia, sprue, idiopathic steatorrhea, and celiac disease, macrocytic anemia associated with surgical procedures or organic disease of the gastrointestinal tract, macrocytic anemia in disease of the liver, infestation with fish tape worm, macrocytic anemia in hypothyroidism, megaloblastic anemia associated with antimetabolites, increased demands for hemo-

poietic factors, and macrocytic anemia developing during pregnancy.

The hypochromic microcytic iron-deficiency anemias are usually associated with impaired absorption, inadequate diet, increased requirements such as chlorosis, and iron deficiency in the male. Chronic hypochromic anemia is also associated with blood loss and hook worm.

Again, to list most of the hemolytic anemias, one would group them as to their extracorpuscular causes, such as infectious agents, chemical agents, physical agents, vegetable and animal poisons, and the idiopathic acquired hemolytic anemias. One would include paroxysmal (cold) hemoglobinuria, chronic hemolytic anemia with paroxysmal nocturnal hemoglobinuria, and hereditary spherocytosis. The next large group would include sickle cell disease, thalassemia, and the abnormal hemoglobin syndromes.

A brief discussion of the aforementioned anemias is in order. In the protocol it was stated that there was slight anisocytosis and slight poikilocytosis in the initial blood study. This would quickly rule out the megaloblastic anemias. In addition, there was no notation of a microcytosis or evidence of iron deficiency. This would be very obvious if the anemia was due to an iron-deficiency state. Furthermore, it is rare for an iron-deficiency anemia to terminate in death.

We have therefore narrowed this anemia down to the normocytic normochromic type. The hemolytic anemias fall into this group. In hemolytic anemias there is a breakdown of the red blood cells and a resulting increase in bilirubin. However, if the anemic process was very slow this might not affect the bilirubin to an appreciable degree. In such a situation the Vanderberg test would probably be of more value. With a hemolytic process so pronounced and an anemia of this magnitude with this fairly rapid course, one would expect a rise in the bilirubin.

We are therefore left with the group of normocytic and nonhemolytic anemias. The mean corpuscular volume of the cells would be 82 to 92% and the mean corpuscular hemoglobin concentration 32 to 36%. An anemia of this type can follow acute hemorrhage, but there is nothing in the history to indicate this.

In this group we find the primary refractory anemias in which there is a pancytopenia secondary to chemical or physical agents, such as benzine, chloramphenicol, benzanthene, gold, other compounds, and ionizing radiation. There are also several less common disorders such as Fanconi's syndrome, "pure red cell" aplasia, and "sideroblastic" refractory anemias. There are also simple chronic anemias. In this group we find the anemia of pregnancy, the anemias associated with inflammation, renal insufficiency and malignancy, vitamin deficiencies, gastrointestional disorders, parasites, and endocrine disorders. In these conditions there is a depressant influence on the bone marrow by the aforementioned conditions. Myelofibrosis is another condition which should be mentioned here. However, it usually occurs later in life. The bone marrow reveals diffuse fibrosis.

The last group which we are all concerned with here is that of the myelophthisic anemias. The reason for centering attention on this group is that there was a significant number of nucleated red cells in the peripheral smears. One would not expect to see nucleated red blood cells in the aplastic anemias, in the pancytopenias, or refractory anemias. In these conditions there is a general and widespread bone marrow depression. Those conditions which give rise to a so-called myelophthisic anemia include metastatic carcinoma, multiple myeloma, Hodgkin's disease, and the primary xanthomatosis. The latter is rather rare and is usually characterized by pigmentation of the exposed skin, is congenital and familial, and predominantly found in female Jewish infants. Malignancies that commonly metastasize to the bone marrow include carcinoma of the breast, prostate, lungs, adrenals, and thyroid. In reviewing this group, the chest x-ray film was negative and there were no physical findings that made us suspicious of a primary neoplasm in these organs. Here we are treading on thin ice, because I am sure you are aware and have seen instances in which the primary malignancy goes practically unrecognized in the presence of extensive metastatic disease. However, this is not the general rule. Multiple myeloma should also be considered.

About 5 per cent of cases have a clinical course resembling that of myelophthisic anemia. Two things might lead us away

from this diagnosis. The syphilis test, frequently found to be positive in multiple myeloma, was negative, and the uric acid level was normal. Up to this point, the bone pain has not satisfactorily been explained. X-ray studies were described as negative in these areas. In the early stages of multiple myeloma, the x-ray studies may be negative, yet considerable involvement of the marrow may be present. Therefore, this condition most satisfactorily serves as the basis of the bone pain on the basis of the information that we have available.

One should also consider Hodgkin's disease. This condition may be present despite the fact that the chest x-ray film showed no demonstrable lymph node enlargement. The axillary nodes would also tend to support this diagnosis. However, if there was axillary lymph node enlargement present we would also expect more hilar node involvement.

For the sake of completeness one should also consider leukemia, particularly in the aleukemic phase. Another possibility somewhat outside the hematological field is that of macroglobulinemia of Waldenstrom. However, the anemia in this case is generally hemolytic. This condition closely resembles multiple myeloma. Bone pain here is not a prominent symptom and diffuse osteopetrosis is seen instead of punched-out bone lesions.

In summary, we have started with the premise that because of the pronounced anemia we are dealing with a problem in the realm of hematology. We have assumed that we are dealing with a normocytic-type anemia and that obvious iron deficiency or microcytosis or obvious macrocytosis would have been noted on a blood smear. We have further ruled out the presence of a hemolytic anemia based on a normal bilirubin. The presence of a significant number of nucleated red blood cells and also some immature blood cells in the granulocytic series has led us to conclude that this anemia was of the myelophthisic type, characterized by marked bone marrow depression yet with other areas of marked bone marrow activity.

My first impression at this point is that the type of the myelophthisic group with which we are dealing here is multiple myeloma. My second impression would be Hodgkin's disease. Laboratory information that would help complete the clinical evaluation in its entirety would be blood indices, serum electrophoresis, a stool urobilinogen, and a bone marrow study. If the first bone marrow study were negative, at least a second, and perhaps a third, would be in order.

DIFFERENTIAL DIAGNOSIS

Dr. S. H. Holt (pathologist): Doctor Mudge's diagnoses in the order in which he gave them are:

1. Multiple myeloma
2. Hodgkin's disease

Dr. Louis Olsman (sugeon): One question which has not been answered in the protocol —had a biopsy been taken on the palpable lymph nodes?

Doctor Burnett: No.

Doctor Olsman: In view of the apparent long duration of this illness, I feel that if this were due to Hodgkin's disease, there would have been some change by this time in the chest x-ray film. This seems to occur frequently. We must remember that all of the patient's symptoms were referable to the right flank and the third rib. Whenever there are essentially normal x-ray films of the gastrointestinal tract, the lungs and the bones, and there is a pronounced anemia such as this, our experience has shown us that we almost invariably find a retroperitoneal lymphoma of some kind. I think that should be strongly considered and my suggestion from a surgical point of view would have been to have taken a biopsy of either rib or lymph nodes or both as soon as the patient was in a condition to have it done.

Doctor Burnett: Would you like to enter that diagnosis, Doctor Olsman?

Doctor Olsman: Yes. Retroperitoneal lymphoma.

Dr. Stephen De Fazio (generalist): Were x-ray films of the skull made?

Doctor Burnett: X-ray films of the skull were made and they were negative. All x-ray studies were negative. These included the entire skeleton and an upper gastrointestinal series.

Doctor De Fazio: In regard to multiple myeloma, usually we find that the patient has a form of albuminuria. This special protein is found in 50 per cent of the cases of multiple myeloma. With all the findings that

I see here and with negative x-ray studies, I see the possibility of exposure to a toxic agent causing this blood picture. I would entertain here the thought that we are dealing with thrombocytopenia due to the possible exposure noted. This would present a picture of thrombocytopenia. There is the possibility of this case being a disease of the liver with some type of a cirrhosis.

Doctor Olsman: Was a complete gastrointestinal series done and found to be negative?

Doctor Burnett: Yes, although it was not in the protocol.

Dr. James Duncan (internist): I would like to make a comment at this point in view of the fact that I saw the patient in consultation during his hospitalization and am aware of the diagnosis. In the history, one of the things that concerned us was the patient's occupation, the dipping of metal into a solution, the fumes of which were considered as a possible source of the type of anemia that Doctor Mudge discussed. Secondly, in considering multiple myeloma, the age and sex of the patient are somewhat against that diagnosis. However, we know it can occur, such as in this individual.

Dr. Michael Miller (thoracic surgeon): Doctor Holt, will you please discuss the difference in diagnosis of subleukemic or aleukemic leukemia as contrasted to multiple myeloma?

Doctor Holt: From the laboratory standpoint, we have changes primarily involving the hematopoietic system. It can be seen that we have some process which is stimulating bone marrow. This can be either physiologic stimulation due to anemia or pathologic physiology due to a myelophthisic process, or the possibility of both must be considered. One will note that there is a marked shift to the left in the granulocytic series of cells, yet there is no elevation of the total white blood cell count. Several pathologic processes can account for a peripheral blood picture of this type. Subleukemic leukemia will frequently occur with immature cells present in the peripheral blood and yet the total white blood cell count will be within normal limits, such as we have here. These cells, though immature, were not a malignant type. The second condition which can cause this effect is an overwhelming infection, which this patient did not have, subjectively or objectively. Examination of the peripheral blood cells showed immaturity, but there was no toxicity present. Toxic granulation of the cells was not encountered and this would tend to rule out the possibility of overwhelming infection causing this type of hematological response. A third condition which can give this type of hematological picture is a myelophthisic type of anemia wherein the bone marrow is stimulated due to invasion of the marrow spaces by nonhematopoietic tissue.

Doctor Wood: I think the lack of a palpable spleen might negate somewhat the thinking of myelophthisic anemia in this particular instance. I would like to mention also the possibility of carcinoma of the pancreas. However, this is not my diagnosis. In this the pain will frequently be relieved with change in posture.

Doctor Burnett: I might add that during this man's hospital stay of three months, neither the liver nor the spleen was ever palpable.

COMMENT

Doctor Holt: I would like to discuss this case using the same sequence in the discussing as we used in studying the case originally. Upon admission to the hospital, the primary feature encountered by the laboratory was the change in the peripheral blood picture. The values and characteristics were previously presented in the protocol. Figure 1, taken on admission, shows two features which are not commonly encountered in simple cases of anemia. There is a rouleau formation of the erythrocytes and the slide appears to have a slight blue cast. Both of these features are abnormal and both are indicative of change in protein. Figure 2 shows a plasma cell which was found in the peripheral blood at the time of admission. Plasma cells are not commonly encountered in peripheral blood smears. When found in the peripheral smear, they are associated primarily with infection, usually of the virus type, and are seen more commonly in infants and children than in adults. The presence of this immature cell in conjunction with the indications of increased protein would make one highly suspicious of a condition producing a macroglobulin such as multiple myeloma or Waldenstrom's macroglobulinemia.

Fig. 1—Peripheral blood smear showing raulaux and "blue" staining characteristic.

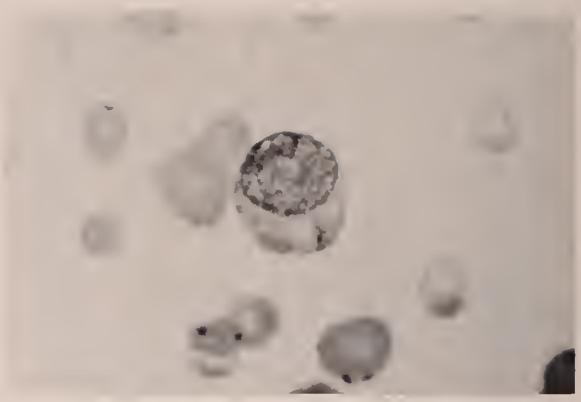


Fig. 2—Plasma cell on peripheral blood smear.

Our next procedure was to do a total protein and electrophoresis. The total protein was found to be 10.5 gm. per 100 ml., which is elevated above the normal range. Figure 3 shows the electrophoretic pattern. There is approximately 50% reduction in albumin content, and a concomitant increase in the globulin in the gamma area. This globulin peak, which is compatable with those seen in multiple myeloma, not only takes the configuration of an abnormal globulin such as multiple myeloma globulin but is also in proper position in its relationship to other globulins in the electrophoretic pattern. The findings of the peripheral smear and of the protein would indicate an excellent possibility of multiple myeloma. The only thing necessary to confirm this diagnosis is a bone marrow biopsy or aspiration. The latter is preferred in this case.

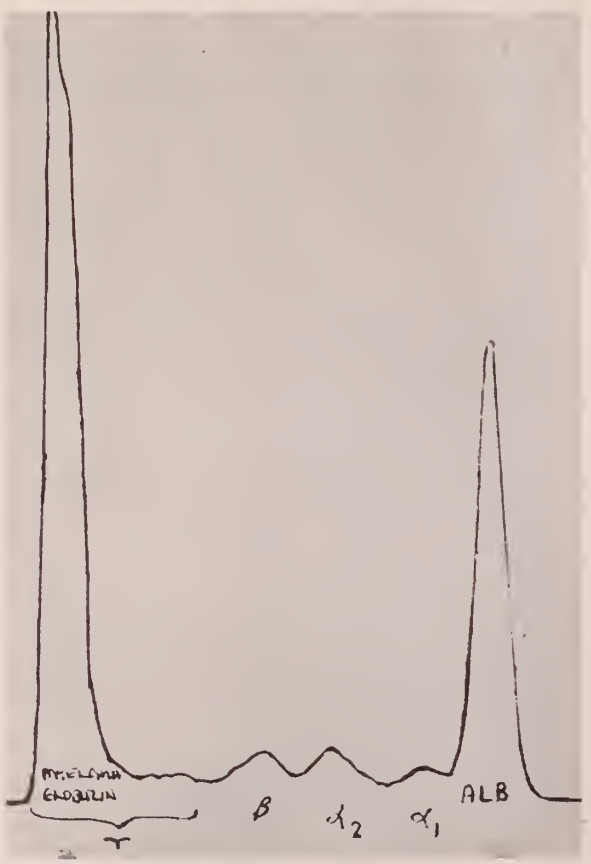


Fig. 3—Electraphoretic pattern of serum.

The marrow was aspirated from the posterior iliac crest, and Figure 4 and Figure 5 show the stained bone marrow aspirate. Figure 4 shows that there is an increased cellularity, although there are no bone marrow particles in this illustration. In addition to the increased cellularity, the cells although not identifiable at this magnification, are appearing in sheets which is indicative of a pathologic process. So at this magnification there are two indications of an abnormality in the bone marrow, namely the increased cellularity and the appearance of the cells in sheets. Figure 5, a higher magnification of the same slide, shows these cells for the most part to be immature and malignant plasma cells. These plasma cells consist primarily of plasmablasts with prominent nuclei.

The patient died after two and one-half months of hospitalization. A postmortem examination was done. The significant findings of the postmortem examination consisted of soft tissue wasting with increased prominence of the bony skeleton, petechial hemorrhages of the mucous membrane and skin, intragastric hemorrhage resulting from multiple large ulcers of the stomach (Fig. 6). These ulcers were metastatic nodules of malignant plasma cells which

subsequently ulcerated. Metastatic tumor was found in the lungs, liver, adrenals, and kidneys. Bone marrow of the vertebral bodies and of the sternum was characterized by replacement of hematopoietic elements by a grey-appearing tumor tissue which microscopically was seen to be sheets of multiple myeloma cells.

FINAL DIAGNOSIS

The final diagnosis is: (1) Intragastric hemmorhage, due to (2) ulcerated metastatic multiple myeloma of stomach wall. (3) Multiple myeloma involving lung, liver, adrenal, kidney, bone marrow, stomach, producing: (4) anemia and thrombocytopenia secondary to bone marrow destruction. (5) Emaciation.

Doctor Burnett: The tumorous condition of multiple myeloma is considered by many to be rare in this age group, as 90 per cent of the patients with multiple myeloma are between the ages of 45 and 70. Our patient was only 35 years of age. In some 25 per cent of the cases, the liver or spleen or both are palpable sometime during the course of the illness. In our case the liver and spleen were never palpable. Ninety per cent of the cases show some degree of anemia and this patient conformed to this finding. Abnormal plasma proteins are present in most cases, although they are not always found in the urine in the form of Bence-Jones protein. Renal disease is very common in cases of myeloma and is characterized by the deposition of an abnormal globulin in the cytoplasm of the tubular epithelium and by the presence of casts in the renal tubules. This ultimately destroys the tubule and fibrosis of the nephron results. Uremia is frequently the final state in cases of multiple myeloma. This case showed only minimal renal involvement from the standpoint of proteinuria and there was no indication of azotemia.

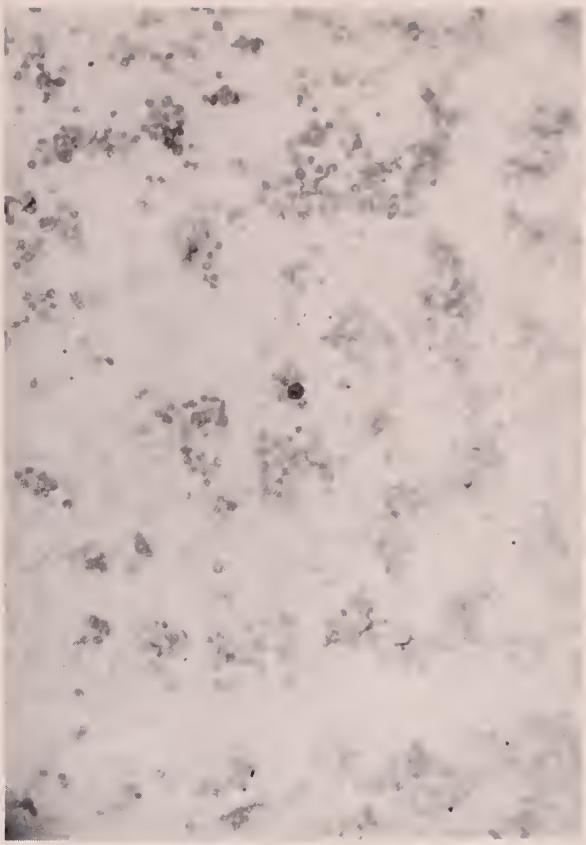


Fig. 5—Bone marrow aspirate, plasma cells (myeloma cells), plasmablasts with prominent nuclei.

There has been an emphasis placed on the finding of Bence-Jones protein in the urine. This protein has been found in only 30 per cent of the cases and is not consistent in its occurrence. All urine specimens may not

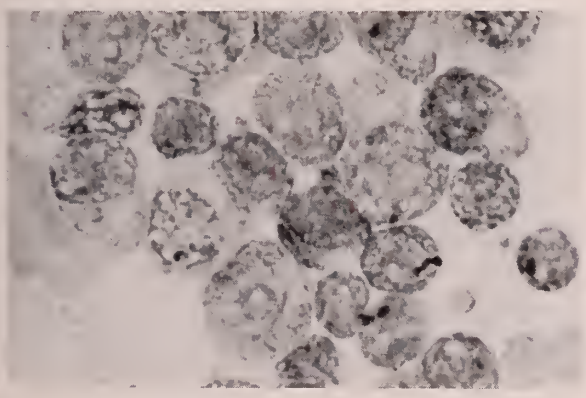


Fig. 4—Bone marrow aspirate, hypercellularity and cells in sheets.

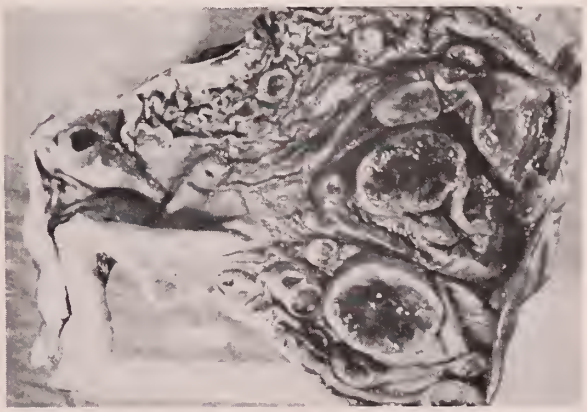


Fig. 6—Ulcerated nodules of myeloma cells in wall of stomach.

contain Bence-Jones protein. Osteolytic lesions resulting in pathologic fractures are present in over 70 per cent of the cases and are usually readily demonstrated by roentgenographic examination. Our patient, however, has no x-ray evidence of bone lesions. Neurologic symptoms of the disease are often pronounced and may be the presenting complaint of the patient. These complaints result from mechanical compression of either the spinal cord or nerve roots, usually as a result of collapse of vertebral bodies.

There has been described a nonspecific polyneuropathy by several observers. Abnormal proteins are frequently found in cases of multiple myeloma. They consist of the so-called myeloma globulin and usually have a molecular weight of near 160,000 and are similar in size and characteristics to gamma globulin. However, this abnormal protein is not the same in any two patients. Each patient has a specific myeloma globulin.

Cryoglobulins are other types of abnormal globulins present in many cases of multiple myeloma. These cryoglobulins are characterized by their ability to be precipitated by cold temperature and they redissolve when warm to body temperature. The third type of protein is the so-called Bence-Jones protein which has a molecular weight of about 44,000. Because of the small size, Bence-Jones protein is rapidly excreted via the kidney and is therefore demonstrated in the urine.

Definite treatment is usually very disappointing. Most of the treatment is palliative, noncurative, and offers at most a variable increase in longevity. Urethane will occasionally give an excellent temporary response. It is used in the dosage of 3 to 6 gm. per day in an attempt to maintain a leukopenia of 2,000 to 3,000 cells per cu. mm. This patient received an average of 2 to 4 gm. per day with absolutely no response. Steroids are indicated especially in cases of purpura resulting from thrombocytopenia. Our patient received 40 mg. of prednisone (Meticorten) daily but this resulted in no demonstrable change. Radiation therapy, both in the form of total body radiation and radioisotopes, had been used but had not been successful from the standpoint of cures. However, local radiation to a painful area or to osteolytic areas will often result in remarkable alleviation of pain and sometimes will result in a reduction in the size of the osteolytic areas. This patient received local radiation to the sacroiliac area with resultant pain relief.

6308 Eighth Avenue.

THE TREATMENT OF RHEUMATOID ARTHRITIS WITH GOLD

M. R. JEFFREY, Tulane University School of Medicine, New Orleans, La., 109:134 (Feb) 1962.

Although gold has been used for treatment of rheumatoid arthritis for over 30 years, few good studies have been reported because of the difficulty of assessing its effects due to the unpredictable nature of the disease. The report of the Research Subcommittee of the Empire Rheumatism Council on this subject is very helpful.

A double-blind trial study was done, using two matched groups of 100 outpatients who had never received gold and who fulfilled certain criteria. The groups were given 20 weekly injections of either 0.5 μg. (controls) of sodium aurothiomalate or 50 mg. (treated) of the same drug. In addition all received basic physical therapy and acetylsalicylic acid as required.

At the end of six months, twice as many treated patients as controls were in the top functional grade and in many of this group active joints had become quiescent. Grip strength, sedimentation rate, hemoglobin level, and the number of analgesic tablets required per day evidenced improvement in the treatment group. However, no difference was noted in the x-ray appearances of the two groups at the end of 18 months.

Fourteen treated patients and 4 control patients were withdrawn from the trial because of toxicity. Dermatitis was the main problem, but it was not severe. Of note was the finding that transient albuminuria was equal in the two groups. The author feels that the high incidence of dermatitis in the treated group (21 cases) is probably dose related and feels that there is a need for further study of urinary excretion of gold levels as a guide to dosage.

This trial shows that gold has a place in the treatment of rheumatoid arthritis. However, further studies are necessary. Whatever the treatment, the clinician is advised not to forget the basic principles of rest, prevention of deformity, and maintenance of function, principles the neglect of which can lead only to disaster.—INTERNATIONAL MEDICAL DIGEST, Vol. 78, No. 6.

A LETTER OF INTEREST . . . .

THE STATE MEDICAL SOCIETY OF WISCONSIN
330 EAST LAKESIDE STREET • MADISON 5, WISCONSIN • ALpine 6-3101

August 2, 1962

TO CHIEFS OF STAFF:
WISCONSIN HOSPITALS

Dear Doctor:

Inquiries have been directed to the Division on Maternal and Child Health of the State Medical Society concerning a new product TOCOSAMINE (Trent Pharmaceuticals, Inc., New York City) advocated for the induction of labor.

The Division wishes to make the following statement for consideration by you and your medical staff:

TOCOSAMINE is the trade name for the preparation of sparteine sulfate, manufactured by Trent Pharmaceuticals, Inc., 233 Broadway, New York 7. It is classified by the manufacturing company as an oxytocic for intramuscular administration in the treatment of desultory labor and uterine inertia.

Because of the potential danger of ruptured uterus if improperly used, it is advised that hospital staffs specify that the use of this drug should be covered by the same staff rules which apply in the use of other oxytocics in your hospital.

It is possible that if sufficient evidence of the safety of this new drug has been accumulated, modification of rules as to its use will be indicated, but until such time the Division urges that its use be subject to the same staff rules as you now apply to other oxytocics used in your hospital.

Sincerely,

John R. Evrard

John R. Evrard, M.D.
Chairman, Division on
Maternal and Child Welfare,
Commission on State Departments

JRE:djl

. . . a public fascinated
. . . a boost for careers in health
. . . an enlightened health 'team'

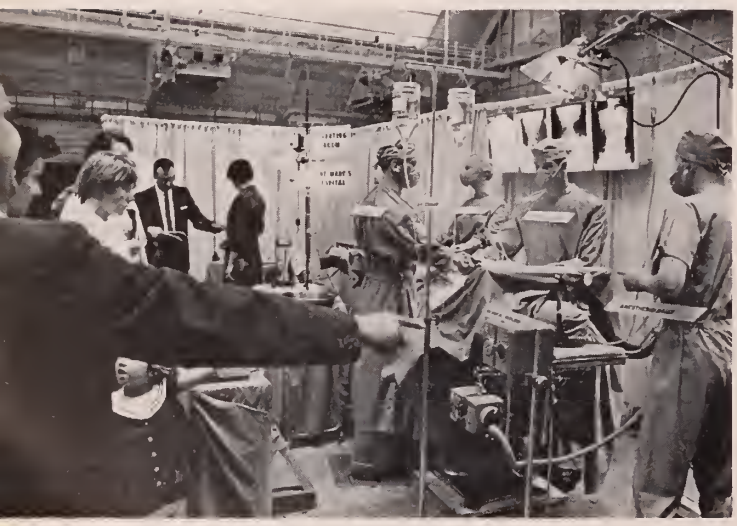
DANE COUNTY MEDICAL SOCIETY

Health Fair

By JAMES F. McINTOSH, M. D., Madison
General Chairman

MADISON was the scene of the first Health Fair ever held in the State of Wisconsin. It was presented by the Dane County Medical Society from May 23–27, 1962. This five-day affair was held in the huge Camp Randall Memorial Building and attracted a total of 82,900 people, many more than anticipated. The Fair was composed of 69 exhibits dealing with medical and health fields. The purpose of such an undertaking was two-fold: (1) to present career opportunities in medical and paramedical fields of endeavor, and (2) to portray medical progress and problems in an interesting, factual fashion.

Such a large undertaking involved over 1,000 people and included 323 physicians of the 450 members of the county society. It required two and one-half years to prepare and was formally opened in a ribbon-cutting ceremony at a special preview held the evening before, on May 22. The late Conrad Elvehjem, president of the University of Wisconsin, performed the honors for the physicians, dentists, pharmacists, veterinarians, nurses, educators and guests. The Fair was paid for by the Dane County Medical Society primarily through a $15.00 assessment of each active member. There was no admission charge and the Fair was devoid of commercial exhibits, advertising or solicitations of any kind.



The privacy of the aperating raam, depicted in detail in an authentic exhibit spansored by St. Mary's Hospital, Madison, was observed with intent curiasity and interest.—Photo by Ed Stein of the WISCONSIN STATE JOURNAL

BACKGROUND

A similar fair held in Columbus, Ohio, in 1959, was publicized and attracted the attention of the public relations committee of the Dane County Medical Society. Information received from Columbus provided the basis of development of this Fair. The response in Columbus was exceptional and the project appeared very rewarding. Preliminary study showed many health agencies and medical facilities interested. The A.M.A. sent descriptive pamphlets describing many exhibits available for only the cost of transportation. Investigation proved a fair to be economically feasible and a plan was offered to the county society in March, 1961, which it approved.

PREPARATION

A basic steering committee was chosen by the general chairman and was composed of: Dr. C. K. Kincaid—health exhibits, Dr. R. J. Botham—hospital

Photo by John Kreissler

The Health Fair's 69 exhibits kept a steady stream of 82,900 visitors wandering attentively through Camp Rondall Memorial Building at Madison for five days in May. Physician-experts were on hand constantly to explain exhibits to the visiting public.

exhibits, Dr. C. W. Stoops—publicity, Dr. P. B. Golden—arrangements, Dr. C. A. Doehlert—school tours. The entire group operated as the budget committee in addition to the above activities. The committee met each month until December, then twice a month until April, then weekly until the Fair was underway.

HEALTH EXHIBITS

Doctor Kincaid invited all health agencies of the county as well as many state voluntary health organizations, dentists, veterinarians, nursing groups and pharmacists to exhibit. The University of Wisconsin presented exhibits on medicine, nursing, medical technology, occupational therapy and physical therapy. These groups were asked only to pay for their exhibits, the decorating and the electricity. A special scholarship booth was also arranged where information concerning scholarships for all types of health careers was available. This included both local and national scholarships. Assembling this information turned out to be a greater task than originally anticipated and the information accrued here will probably be kept as a current file and available for students and schools upon request.

Seven A.M.A. exhibits were utilized. These were of excellent quality and very interesting. The "Life Begins" exhibit proved to be the most popular of the Fair. The "Transparent Woman" was also constantly attended. The Dane County Veterinary Society also had an engaging exhibit with live dogs and a cow with a permanent gastrostomy used for research purposes at the University. The Dental Society showed both the old and ultra-modern dental drills and visitors were allowed to operate them.

HOSPITAL EXHIBITS

Doctor Botham contacted all hospitals in the Madison area and obtained their agreement to sponsor various exhibits which were suggested by the steering committee. In addition, special subjects were sponsored directly by the Dane County Medical Society. These were exhibits on ear, nose and throat, eye, anesthesia, psychiatry and cytology.

Outstanding exhibits were the heart pump, the artificial kidney, the operating room, the cast room, electrocardiography and cytology. Exhibits in this group were manned by physicians. *This personal contact with a physician expert in a particular field was the most important factor of success in our Fair.*

An unexpected development occurred in the cast room exhibit. As planned, the orthopod would periodically demonstrate how a simple cast was applied to the forearm. School children were enthralled by these casts and wore them home (bivalved) and to school the next day. This caught the fancy of the other students and became a status

symbol. Soon the crowds of students at this exhibit caused a traffic problem. On Saturday it was necessary to move the exhibit or move the children. It was elected to move the children and this was accomplished by drawing numbers from a hat at one end of the building. The winners were given a cast. This was so exhausting and seemed to be deviating from the basic goal of the Fair, so that on Sunday, the last day, the application of casts was stopped altogether. This was in spite of complaints of parents who were not upset that their child had a cast, but were asking why their child was left out.

The electrocardiographic exhibit contained an oscilloscope to which wrist band electrodes were connected and a physician could point out to the visitor sitting in the chair what his electrocardiogram was all about. Several previously unknown abnormalities were discovered during the course of the five-day Fair and the patients referred to their family physicians. The cytology group constructed a giant microscope containing two large blown-up Kodachrome slides. One was placed in each eye piece. One slide showed normal cells and the other showed neoplastic cells. This interesting exhibit was well received and understood by the public and was so impressive that the State Medical Society asked for it to be used in the Museum of Medical Progress at Prairie du Chien.

Dr. Arch Cowle, Quisling Clinic, Modison, is shown preporing to bivalve two recently opplied costs at the orthopaedic exhibit. The overpopulority of cost applicotions among the school children coused o troffic problem thot finolly necessitoted their being discontinued.—Photo by Ed Stein of the WISCONSIN STATE JOURNAL

SPECIAL EXHIBITS

Dr. Arch Cowle developed a closed circuit television surgical program by creating a video tape of various surgical procedures. The crew from WHA–TV did the technical work and were most generous and cooperative in providing time and materials at cost to the Dane County Medical Society. A two-hour show was presented each evening plus Saturday afternoon. The public's fascination for this sort of activity was readily demonstrated here. A printed program of the procedures being viewed with a brief description was given to each viewer. The Society purchased this tape on the chance that it might be used again. So much time and effort had gone into its creation that it seemed a shame to destroy the tape.

The Fire Department brought its emergency rescue vehicle and team with its equipment to the Fair. The public was treated to a visit to the truck and a lecture concerning how each piece of equipment was used. This included a demonstration of mouth-to-mouth breathing.

The State Health Department exhibited its x-ray bus and took over 300 x-rays. One mediastinal tumor was discovered and has already been treated. Nurses

Dr. Vincent Gott, University Hospitals, was on hond to exploin the heart-lung machine.—Photo by Ed Stein of the WISCONSIN STATE JOURNAL

in the bus also took blood pressures. This type of activity has been carried on for several years by the State Department of Public Health.

Dr. Gordon Garnett and his committee of Dr. Thomas F. Heighway, Dr. Frederick Pitts and Dr. Paul Vastola created a huge entrance exhibit, an electronic map of the United States 12 feet tall and 20 feet long. It depicted where each Dane County physician was born and trained. A 3½-minute tape recording was synchronized with the several hundred lights and the map operated on a photo-electric cell. This exhibit also will go to the Museum at Prairie du Chien. This vast amount of electronic creative ability was the work of Dr. Thomas Heighway who spent untold hours wiring the map.

PUBLICITY

This committee, headed by Dr. Charles Stoops, was composed of Dr. William Rock, Dr. Robin Allin and Dr. Russell Sinaiko plus one representative from the press, radio and television. All media were utilized in publicizing the Fair. Early publicity included discussions at various service clubs, bumper stickers, posters and mailing stuffers. Several television shows were held a few days prior to the opening and T.V. and radio "spots" were heard for two weeks before the Fair. A special 28-page supplement was created by the Madison Newspapers, Inc. and sent out with each of the papers just prior to the Fair. The supplement was paid for entirely by advertisements. The supplement contained feature stories on all aspects of the Fair. The Mayor of Madison proclaimed the week as Health Careers Week and all news media were invited to the special ribbon-cutting preview held the night before the Fair opened.

SCHOOL TOURS

Five thousand school children, mostly ninth graders, were given conducted tours of the Fair. These tours were on Wednesday, Thursday and Friday from 9:00 a.m. to 3:00 p.m. The Fair was not open to the public during these hours. Assisting Doctor Doehlert were Dr. Robert Beilman, Dr. Laurence Crocker, Dr. William Crowley, Dr. Robert Wylde and Dr. Eugene Skroch. The Dane County Medical Society Auxiliary provided the tour guides and did an outstanding job. The tours lasted approximately one hour and the Dane County Medical Society paid for bus transportation of these children from the city schools to and from the Fair. It required a well coordinated effort and a tight schedule to prevent conflicts; however, the entire project went off practically without a hitch. This was in spite of the fact that many large groups of children from out of town came without warning at inopportune times.

It was felt that these tours were the most important features of the Fair. The response was very gratifying and many children returned in the evening with their parents to see things that they had missed. It was not possible in one hour to see all of the Fair. This, of course, was precisely the effect the committee had hoped for as children are good advertisers. Their enthusiasm brought many a parent to the Fair who had not planned to attend. Once there, there was no problem in maintaining their interest.

ARRANGEMENTS

Dr. Peter Golden was a one-man committee and performed a marvelous task. He was aided by Mr. Roy Ragatz of the State Medical Society and Mr. Fred Wilcox, superintendent of buildings of the University of Wisconsin. The cooperation of the University of Wisconsin, particularly the athletic department whose building was being used, made the task much easier. The building was rent free, although the Society paid for electricity, workmen, guards and parking attendants.

School children on specially conducted tours listened on phones to a pretaped story on anesthesia. Madison's anesthesiologists produced this informative exhibit.—Photo by Ed Stein of the WISCONSIN STATE JOURNAL

Three outside telephone lines were installed to be used by physicians and exhibitors at the headquarters booth. This booth was manned at all times by a steering committee member and two members of the Dane County Medical Society Woman's Auxiliary. A P.A. system was available as was an intercom telephone to the information booth. The information booth at the entrance was manned by the Dane County Dental Society Auxiliary, and served as headquarters for the school tours. A hostess lounge was created behind this area.

The concessions were run by the University of Wisconsin athletic department and it received the profits from these concessions. The only control the committee exerted was to disallow the sale of pea-

nuts or popcorn because of the clutter caused and the resulting cleanup problems.

The decorator, Mr. Robert Otto of Chicago, brought his crew into the building on Sunday and Monday and the area was ready for exhibit construction on Monday. The committee asked that all exhibits be finished by Tuesday afternoon and ready for the Fair opening that night. This schedule worked without difficulty.

CREDITS

It would be erroneous and unfair for the Dane County Medical Society to assume 100 per cent credit for this large show. It received valuable clerical and advisory help from the State Medical Society and the American Medical Association. From the University of Wisconsin athletic department, building and grounds personnel, WHA–TV staff and those from the Bureau of Audio-Visual Instruction the Society was given assistance in fields with which it was generally unfamiliar. Local radio, television and newspaper representatives served on the publicity committee. Local hospitals were generous and willing to support this project without hesitation. They assisted in recruiting hospital personnel for special duty at the Fair.

A large credit is due to the auxiliaries. The Dane County Dental Society Auxiliary operated the information booth with two women present at all times. Approximately 43 of the Auxiliary assisted in this project. Approximately 70 members of the Dane County Medical Society Auxiliary assisted. They aided in the distribution of posters to all local business establishments and offices and also supplied personnel for the headquarters booth, manning the P.A. system, and the telephones. Their biggest effort, however, was providing tour guides for the school children. This required considerable time and effort, but proved to be very rewarding.

SUMMARY

It is too soon to add up all the benefits of such a project. Some have been realized already. Congratulatory letters from many people attest to the universal appeal of the Health Fair. Many physicians had not realized how fascinated people are about medicine. It was also obvious by the interest shown by the students that physicians have been derelict in not publicizing health professions to a greater degree before. The public was impressed that the physicians of their community took the time to work at the Fair and sell themselves and their profession. This impressed more than the fact that we were paying for the Fair.

And finally, this Fair in some way perhaps, may help all of us in this county feel more proud of our Society and enhance a greater spirit of friendliness and understanding.

THE TINE TEST

By RICHARD J. JAHN, M.D.
Milwaukee, Wisconsin

It is now almost 72 years since Robert Koch first developed his Old Tuberculin which eventually evolved into the skin test for tuberculosis. During the decades that have passed, much time, money and effort have gone into the development of an accurate, reproducible, sensitive, specific skin test for tuberculosis. This, of course, is the intradermal Mantoux using carefully measured, highly purified PPD. The test has, however, one well known defect. It is time consuming and needs skilled personnel to administer.

To overcome this defect, multiple puncture techniques have been proposed. One of these, the Heaf test, originally developed in 1955, has been shown to be different from the Mantoux test in many respects with some serious drawbacks. Currently, in Wisconsin another skin puncture test, the Tine test, is being widely promoted. The data concerning the reliability and limitations of this test are very limited indeed. Because of this, the Wisconsin Anti-Tuberculosis Association is presently engaged in a comparative study of the Tine test and the intradermal Mantoux. It is contemplated that after approximately 10,000 tests have been completed, which should be in the summer of 1962, some reasonably reliable data concerning the Tine test will be available.

It is strongly urged that the physicians in this state withhold usage of the Tine test until sufficient data concerning the test has been accumulated.

Presented at the request of the State Medical Society's Division on Chest Diseases of the Commission on State Departments.

THE PRESIDENT'S PAGE . . .

Immunization

THE ANNUAL FIRST DAY of school brings problems to physicians as well as to parents and teachers. The preparation of children for this important event begins with the selection of proper clothes and new shoes and the inevitable school examination. It is discouraging to our profession to see how little heeded is our advice for early vaccinations. We know that some of the communicable diseases can be prevented by active immunization, but full value of all the recent research on polio, measles, and mumps vaccines is not realized if the public fails to take advantage of it.

A program of immunization should be the most important part of a child's medical history. All infants should be immunized against diphtheria, pertussis, and tetanus, simultaneously, with injections of the combined antigens. The new preparations result in greater antigenic stimulation against pertussis in early infancy, and produce prolonged antitoxic immunity.

In older children and adults, tetanus becomes a problem from cuts and puncture wounds contaminated with soil. Revaccination should be done on a regular recurring schedule, so that when such a wound does occur, a single dose of tetanus toxoid will confer adequate protection.

Initial vaccination against smallpox should be done during the first year of life, so that immunity develops before any risk of exposure. This should be repeated before entering school, as the only real test for immunity is the immune reaction to revaccination. In many communities, parents neglect this important aspect of preventative medicine. Epidemics can occur because of such lapses, as happened in England the past year. A highly desirable piece of legislation would be the requirement of a certificate of vaccination for admission to all of our public schools.

The recent dramatic decrease in paralytic polio cases has been due to the rather limited use of Salk vaccine, given hypodermically. It is to be hoped that the more general use of the oral Sabin vaccine will result in further immunization of our population. Civic organizations could join the medical profession in aiding the current campaign for mass immunization against polio this fall. Their help is needed particularly to stimulate

(continued on page 446)

THOUGHTS OF A NEW PRESIDENT

Our privileged place in society attracts difficulties and troubles; to paraphrase the Bible, we are born unto trouble as the sparks fly upward. It was ever thus, it will always be so. For we are, as it were, by training, tradition and the nature of our work, a race apart. We are never really completely integrated into a community. Individually, we are respected, liked, even loved by our patients in the main; but too frequently, our reward for honest endeavour and sacrifice for the sick is none other than sheer ingratitude. Nor is this a new development in the doctor-patient relationship. Over 4 hundred years ago, John Owen (1560–1622) noted it in this epigram:

> God and the doctor we alike adore
> But only when in danger, not before;
> The danger o'er, both are alike requited,
> God is forgotten, and the doctor slighted.

Collectively, we are treated with suspicion. Our motives are often questioned and suspected by the public. Often we are not given credit for worthy motives, and our ethical standards, because not understood, are assailed and given a sinister interpretation. Politicians understand this foible of the public very well, and they are wont to play on these fears, suspicions—yes, even jealousies—of the electorate for very unworthy motives. For, numerically, we are contemptible from a franchise standpoint, and ethically, we are handicapped in defending ourselves.—B. A. Cook: An Address: Thoughts of a New President (New South Wales Branch of the British Medical Association), *The Medical Journal of Australia*, June 4, 1960.

THE BEST DRUGS ARE YET TO COME

There is no question that in the United States, it has been the pharmaceutical companies who have done the major research work in the discovery and the initial testing of the drugs we call the tranquilizers. I think we owe a great debt of gratitude to these companies for this research job. I have the impression that when this whole new concept of the treatment of mental illness by drugs was begun, had the control of it, and particularly the "efficacy" of these drugs been a matter of jurisdiction by the Federal government, my guess is we would not have had them. I think it was the competitive research activities among the drug houses that led to these—and fortunately for all of us in this field, still continues. My conviction is that the best of the drugs is probably yet to come, and the chances are good that it will come out of the research, the competitive research if you will, among the drug houses.—William C. Menninger, M.D., The Menninger Foundation, to Senate Subcommittee on Antitrust and Monopoly.

THE PRESIDENT'S PAGE *(continued from page 445)*

public interest and to keep individual records. Unless this project is done on a community-wide basis, the benefit will not be so great as desired.

Since a possible influenza epidemic is predicted, children over 5 years of age, as well as adults, should be inoculated against influenza. Among adults, those with debilitating or degenerative diseases, pregnant women, and those in constant contact with the public should also be immunized.

Rabies may be contracted from pets or other animals, such as bats, skunks, or squirrels. When such exposure occurs, a series of the improved Pasteur rabies inoculation must be instituted promptly.

Although the oral Sabin vaccine is in the spotlight at present, this only serves to focus interest on all other types of immunization. We should use this as an opportunity to increase immunization against all the common communicable diseases as our best means of preventative medicine.

the WISCONSIN MEDICAL JOURNAL
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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Saturated Banana Oil

IN HIS HUNGER for information, the average American has a healthy respect for the printed word. If the book he buys is respectably made, published by a reputable, well known firm and sold through regular channels, there is little reason for him to doubt the integrity of what he reads. If the argument is plausible and pleasant to accept, and if the author appears to be qualified, the reader will take seriously what he reads. That's why *Calories Don't Count*, nominally by Herman Taller, M.D., sold over a million copies before the Food and Drug Administration cracked down on it.

Published by Simon and Schuster, which is not the least of the American publishing houses, *Calories Don't Count* preached the comforting doctrine that persons who wanted to reduce their weight could continue to eat as much as they wanted as long as they swallowed six capsules of safflower oil each day. Fortunately for the American public—and unfortunately for the promoters of the book, who also manufactured and sold safflower oil capsules—the first editions of the book mentioned a specific brand of safflower oil. Since the commercial reference constituted labelling under the Federal Food, Drug and Cosmetic Act, the FDA was able to take action to stop the sale of safflower oil through banana oil.

If the promoters of safflower oil capsules had not been so greedy, however, *Calories Don't Count* would still be on sale at bookstores. Other "health" books, like *Folk Medicine*, by Dr. D. C. Jarvis, still crowd the bookshelves. Some of them are of doubtful value, some offer false and misleading information, and some are downright crackpot. Many of them sell well, making fortunes for their authors, publishers and promoters. The eager searcher for the word that he would like to hear, the credulous, the desperate are gulled with palatable misinformation before the fad has run its course or the FDA has cracked down.

The publishing of phony health books cannot be stopped. Under our constitutional guarantees apparently anyone can write a book, no matter how false the idea he tries to sell. Only if the author and publisher run athwart the labelling laws can the book be removed from the market. Obviously, however, the public has a right to be protected from decep-

tion through reading books as much as from deception through reading labels. If the FDA can't act quickly enough, or often enough, other means must be found short of censorship.

The American Medical Association cooperates with the FDA to identify and stop medical frauds and quackery. By the same token, the AMA is the logical organization to identify "health" books that give false and misleading information, and counteract them with an aggressive program of publishing authoritative information. Frequent press releases with facts offered by recognized experts could scotch the sale of books like *Calories Don't Count* long before its promoters have made their boodle and long before millions of uncritical laymen have paid their hard earned cash for nonsense.

If it is to be effective in its function to safeguard public health, the AMA must act as a watchdog of public information regarding health. It has an obligation to recognize the damage that can be done by the quackery of "health" books and to take strong measures to oppose them. We can hope that the AMA will soon establish effective mechanisms to throw the strong, bright light of truth on some of the tortured hokum being sold as health information in the bookstores of the nation. —D.N.G.

A Real Value

THE DOCTOR who takes seriously his obligation to keep current with the progress of his profession will be found attending the 47th Scientific Assembly of the Interstate Postgraduate Medical Association. Consisting of four days of panel programs, teaching sessions and symposia, the assembly is especially designed for the physician concerned with modern therapeutic methods.

In addition to the scientific programs, the assembly will feature social events for both the doctor and his lady, including a banquet at which General Alfred M. Gruenther, former supreme commander of Allied powers in Europe and now president of the American Red Cross, will speak on "American Problems in an Uneasy World."

The assembly will take place at the Palmer House in Chicago, October 1 to 4. For full information and reservations write to Interstate Postgraduate Medical Association, Box 1109, Madison 1, Wisconsin. If the address seems familiar, it is because our own Roy Ragatz, who is unexcelled in the intricate business of staging large medical meetings, is the major-domo.

"Real Value," Roy says enthusiastically. "You'll find it a program extremely practical in character." —D.N.G.

COMMENTS FROM THE PRESS

Medicare Expected Back Another Time

Dr. Ralph Frank [Eau Claire] explained the opposition's views on the Senate-defeated medical care for the aged bill to the Lions Club Wednesday.

The so-called Medicare bill, formerly known as HR 422 or the King-Anderon bill, is not a "dead horse" because the administration has let it be known it will be a campaign issue and also, he said, it or similar bills are likely to be considered at future times.

Doctor Frank said the proposal is not an insurance, but a tax. He called it unfair in that it covers the wealthy as well as the poor; it gives unearned benefits to the recipients and puts the burden on the young.

He called the King-Anderson bill a "cruel hoax" because it is inadequate, does not include surgery and covers only 25 per cent of medical costs. He said the estimated initial $1 billion annual cost of the program was a vast understatement. He charged that the government based their cost figures on a survey in which they asked elderly people what they recalled their medical expenses during the previous year were.

Another objection raised by Doctor Frank is that the bill dictated what drugs could be used in that it would exclude the newest drugs because only those in the profession's guide books could be used.

On the other hand, Doctor Frank said that the Kerr-Mills bill passed in 1960 which calls for matching federal and state funds, pays total cost (with some exceptions) and provides a "means test," is as near to perfect as possible. Twenty-eight states now operate care for the aged under this bill, he said. The Wisconsin legislature has yet to complete action on participation due to the redistricting problem, he said.—Reprinted from the EAU CLAIRE LEADER, July 19, 1962.

THE MEDICAL FORUM

Wisconsin Work Week of Health Dates Set

The Wisconsin Work Week of Health, designed to focus statewide attention on recent advances and special problems in medicine and public health, will be held February 18–23 at the State Medical Society headquarters in Madison.

Discussions will center on topics such as youth and health, the senior citizen and health, public health and Wisconsin, industry and health, medical education and hospitals, and interprofessional relations.

One-half to a full day will be devoted to each subject, with speakers from both Wisconsin and out of state presenting papers on the problem areas and fields of interest within each topic.

Participation will cover a wide area—guests will be invited from each segment of the population interested in the subject presented on a specific day.

All meetings will be held in the meeting room of the new addition to the State Medical Society building presently nearing completion.

With meetings all during the day, evenings will be devoted to sessions of State Medical Society committees and statewide organizations interested in the topic of the day.

On Saturday, Feb. 23, the annual County Medical Societies Presidents and Secretaries Conference will be held.

Concept of the Wisconsin Work Week of Health originated with the Council. That group, through its executive committee, is planning the week's activities after consultation with the various committees, commissions and divisions involved.

Topics for the week-long event have evolved over the past few years upon recommendation from these groups of physicians, through their committee activities.

The Wisconsin Work Week of Health represents one of the most ambitious undertakings ever attempted by the State Medical Society to provide information and initiate action in a wide field of health topics.

Detailed program arrangements will be announced in the *Wisconsin Medical Journal*, other Society publications, and the public news media as they are completed.

Health Board Recommends Two Immunization Methods

The continued use of Salk vaccine and of Types I and II Sabin oral vaccine has been recommended by the Poliomyelitis Advisory committee to the State Board of Health. Type III oral vaccine is recommended for use under certain conditions, according to Dr. Josef Preizler, chairman of the committee.

The recommendation states: "On the basis of present information the committee recommends either of two methods for immunizing against poliomyelitis:

1. Continue with the immunizations using the Salk vaccine with the understanding that periodic booster doses will be required.
2. Use type I and II oral vaccine without restriction and type III Sabin oral vaccine only for those persons who have had Salk vaccine, the last dose of which shall have been given within one year prior to the feeding of type III.

> "It seems to be advantageous that type I oral vaccine shall be used as a first dose followed by type II after six weeks, and the type III to be administered after an interval of at least eight weeks following the type II feeding."

Members of the advisory committee in addition to Doctor Preizler who is director of the Division of Communicable Disease Control include: Drs. Ruth Church, Waukesha; N. A. Hill, Charles K. Kincaid, William E. Meisekothen, Horace K. Tenney, III, and James L. Wardlaw, Jr., Madison; Edward R. Krumbiegel, Milwaukee; J. R. Schroder, Janesville; G. G. Shields, Wisconsin Rapids; and Leon Gilman, D. O., Milwaukee.

Counties which have planned fall mass immunization programs include: Antigo, Chippewa, Dane, Door, Douglas, Grant, Green, Kenosha, Lafayette, Pierce–St. Croix, Portage and Racine. In some instances these plans may have been changed because of the State Board of Health's recommendation.

DEARHOLT DAYS NOV. 13–14

Dr. Oscar Auerbach, senior medical investigator for the Veterans Administration hospital in East Orange, N. J., will be the 1962 speaker at the Wisconsin Anti-Tuberculosis Association's Dearholt Days programs.

A pathologist well-known for his research on tuberculosis and lung cancer, Doctor Auerbach will speak at Marquette University November 13 and at the University of Wisconsin in Madison November 14.

New Museum Building Honors Doctor Stovall

Dedication of the Stovall Hall of Health was held Sunday, September 23, at the Museum of Medical Progress in Prairie du Chien, Wis.

The new building, the third in the medical museum complex, is named in honor of Dr. William D. Stovall, Madison, president of the Charitable, Educational and Scientific Foundation of the State Medical Society.

The museum is a project of the Foundation, and is operated by the State Historical Society of Wisconsin as one of the five major historical sites in the state.

WILLIAM D. STOVALL, M.D.

Main speaker at the event was Clifford *Lord*, dean of the School for General Study, Cornell University. Lord was director of the State Historial Society when preliminary arrangements were made to establish the museum.

He outlined the development of the Museum of Medical Progress, which is gaining national recognition as a historical attraction, and praised the work of Doctor Stovall in the many years' work necessary to accomplish the project.

Extending the welcome to the many physicians and others who attended the event was Dr. E. M. **Dessloch**, Prairie du Chien, councilor of the fourth district. Dr. N. A. **Hill**, Madison, president of the State Medical Society, paid tribute to Doctor Stovall as a dedicated physician and medical statesman and William B. **Hesseltine**, Madison, president of the State Historical Society, reviewed his accomplishments as a historian, both in the establishment of the museum and as a curator of the historical society for many years.

The program concluded with a response by the honored physician and a tour of the new building conducted by Gordon *Peckham*, Prairie du Chien, curator of the museum.

The 98 by 40 foot building, completed in late August, triples the exhibit space at the museum. On exhibit for the remainder of the 1962 site season are a number of displays on pioneer Wisconsin physicians, surgery, cosmetic surgery, dermatology, nursing, general health topics, and space-age medicine. A movie theater is also included.

These are added to the initial displays in the restored military hospital of the Second Fort Crawford which portray progress in medicine from the frontier days up to the present time, including the story of Dr. William Beaumont's experiments in the physiology of digestion.

The museum will remain open through October 31.

Annual Meeting to Honor Marquette

Alumni of Marquette University School of Medicine have been invited to present papers at the 1963 annual meeting of the State Medical Society in recognition of the 50th anniversary of the medical school. The meeting is scheduled for May 6, 7, 8 and 9 in Milwaukee.

Other features of the annual meeting program include a full-day conference on medical care of the aged on Tuesday, May 7. On Wednesday, May 8, there will be a one-hour cancer symposium on chemotherapy and lectures on psychiatry, antibiotics, obstetrics and gynecology, pathology and radiology.

Tentative plans for the final day, on Thursday, May 9, include a conference on medical aspects of sports with emphasis this year on knee injuries and dermatitis in relation to sports, and lectures on anesthesiology, pediatrics, ophthalmology and otolaryngology, and surgery.

The Commission on Scientific Medicine is in charge of arrangements for the annual meeting. Dr. R. W. **Farnsworth**, Janesville, is general chairman; Dr. A. R. **Curreri**, Madison, chairman of the scientific program; Dr. P. T. **Bland**, Westby, chairman of luncheons and special events; and Dr. G. E. **Collentine**, Jr., Milwaukee, chairman of the scientific exhibits.

MILWAUKEE MEDICAL CONFERENCE PLANNED

The second annual Milwaukee Medical Conference will be held at Milwaukee County Hospital on November 14 and 15. The conference, sponsored by The Medical Society of Milwaukee County in cooperation with five other Milwaukee medical organizations, is open to all physicians.

Co-sponsors of the program are the Milwaukee Academy of General Practice, Milwaukee County Hospital, Marquette University School of Medicine, Veterans Administration Center, Wood, and Milwaukee Children's Hospital.

Members of the Milwaukee Medical Conference planning committee are: Drs. Edwin H. **Ellison**, chairman; Robert E. **Callan**, William H. **Frackelton**, William W. **Engstrom**, Roman E. **Galasinski**, president of the Milwaukee Medical Society, and Robert A. **Frisch**, president-elect of the Society.

Members of the Milwaukee Medical Society program committee are: Doctors Ellison, chairman, Frackelton, vice-chairman, Callan, Engstrom, Mark J. **Ciccantelli**, James E. **Conley**, Paul **Kimmelstiel**, Walter P. **Blount**, Maurice **Hardgrove**, George A. **Hellmuth**, William F. **Hovis**, Jr., Joseph F. **Kuzma**, Charles H. **Altshuler**, Norbert G. **Bauch**, Albert H. **Pemberton**, Albin J. **Krygier**, Mischa J. **Lustok**, and Wilson **Weisel**.

Achievement Award to Hayward Hospital

"Small in size, but big in service," might well be the motto of the Hayward Area Memorial Hospital which received the 1962 Hospital Achievement Award of the State Medical Society of Wisconsin in recent ceremonies at Hayward.

Operated as an Indian hospital by the Department of the Interior up until nine years ago, the hospital has since grown to serve a 2,000 square mile area in Wisconsin's north country.

DR. N. A. HILL (right), president of the State Medical Society of Wiscansin, presented the 1962 Haspital Achievement Award ta the Hayward Area Memarial Hospital in ceremanies held an the haspital graunds. Receiving the award is William O'Brien, Hayward, president af the advisory baard af the haspital.

It is on the basis of its present outstanding service, made possible through the combined efforts of the hospital and its medical staff, that the award was voted by the Council of the State Medical Society of Wisconsin at the annual meeting in Milwaukee in May.

Praising the hospital for improvements in its facilities and services, Dr. N. A. Hill, Madison, president of the State Medical Society, pointed out the x-ray and laboratory departments, patient record keeping system, special clinic for Indian residents, fire safety program, mass casualty program, and addition of new equipment.

"But it is people who make a hospital—not brick, mortar, beds, furniture and operating tables," he added. "The people who are employed in a hospital to carry out the orders of the physicians are the ones who set the tone and thought of the proper standards of hospital care."

"This has been done by your people who serve you in your hospital," he concluded.

Receiving the award for the hospital were William O'Brien, Hayward, president of the advisory board of the hospital; Dr. E. R. Krueger, Hayward, chief of the medical staff and Michael H. Wiess, Jr., Hoopeston, Ill., administrator of the hospital during the period for which the award was made.

Also on the program, held on the hospital grounds, were Dr. James C. Fox, La Crosse, chairman of the Council of the State Medical Society; Dr. W. J. Egan, Milwaukee, president-elect of the State Medical Society; and Paul A. Balerud, Hayward, present administrator of the hospital.

Other representatives of the State Medical Society were Dr. V. E. Ekblad, Superior, and Dr. R. C. Frank, Eau Claire, both councilors; and Dr. T. E. Boston, Hillsboro; Dr. P. P. Cohen, Madison, acting dean of the University of Wisconsin Medical School; and Dr. C. J. Picard, Superior, all members of the Society's Commission on Hospital Relations and Medical Education, which recommended the hospital for the award.

NEUROLOGICAL CENTER PURCHASED BY STATE

The Wisconsin neurological hospital at Madison has been purchased by the State of Wisconsin and will be operated by the University of Wisconsin.

It was purchased from the Wisconsin Neurological Foundation, Inc., a nonprofit organization which had closed its doors June 15 because it was operating at a financial loss.

Purchase price of the hospital, which, with its equipment, is valued at $1.1 million, was $575,000. Dr. Philip Cohen, acting dean of the University of Wisconsin Medical School, estimated it would cost $2 million to reproduce the hospital on the university campus.

News Briefs

FUTURE PHYSICIANS CLUB

A future physicians club is being developed by the Dane County Medical Society to help high school students find out more about medical education and the medical profession. Open to junior and senior students in Madison's East and West high schools, the clubs are designed to present information about premedical education, medical school, internship, residency and medical practice.

Two Madison physicians, Dr. James F. Land and Dr. Gerald J. Derus are in charge of the program.

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FDA Bans Distribution of Neurolinometers

Distribution of new, used or repaired models of seven worthless health devices, including the "black box" or Neurolinometer, has been banned permanently by the Federal Food and Drug Administration through federal court action.

Although the color of these newer "research models" has changed from black to grey, all are outgrowths of the original Neurolinometer which was declared a fraud in 1958 by a Wisconsin court.

Misbranding under the Federal Food, Drug and Cosmetic Act was charged because labeling on the devices failed to bear adequate directions for use in the diagnosis of disease and no such directions could be written because they are worthless for diagnostic purposes.

Other devices banned are known as Radioclast Model 40, Radioclast Model P, Radioclast Treating Unit, Electron-O-Ray 46, Electron-O-Ray Model 51 and Quto-Electronic Instrument Model O-20-1P.

Federal Judge Frank L. Kloel signed a consent decree of permanent injunction restraining Electronic Instrument, Inc., Tiffin, Ohio, Dale C. Mowery, its president, and Helen R. Mowery, its secretary and treasurer, from further shipment of the expensive but useless machines. FDA said thousands of the instruments, costing up $1,000 each, have been distributed over the years.

In June, 1958, the United States District Court for the Western District of Wisconsin condemned the use of six Neurolinometers seized from the Toftness Chiropractic Clinic at Cumberland. The action in this case was directed against the misbranded Neurolinometer devices and not against any chiropractor or system of chiropractic, nor did it involve any state or other regulations governing the practices of chiropractors.

The Toftness Chiropractic Clinic at Cumberland, originated in 1932 by Irving N. Toftness and operated with his brothers, Gordon N. and F. L. Toftness, developed the Toftness System of Chiropractic, which involved the claimed diagnosis of practically all human diseases by the use of the Neurolinometer. The system also included a training program in which other chiropractors visited the clinic for a period of three to six weeks and took training in the diagnostic use of the Neurolinometer.

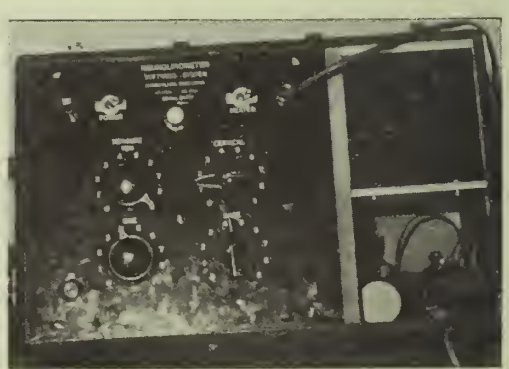
Upon "graduation," the visiting chiropractors were charged $500 for the training and $165 for a Neurolinometer, which they carried back to their own offices and continued to use in the diagnosis of disease. Supplying the Neurolinometers to the Toftness Clinic was Electronics Instrument, Inc., Tiffin, Ohio.

Following the condemnation of the Neurolinometer by the United States District Court at Madison, an elaborate "leasing" scheme was set up by the inventor and marketer of the machine designed to avoid similar action by the U. S. Food and Drug Administration against the later "research models."

In Wisconsin, the State Board of Chiropractic sought to adopt rules that would permit continued use of such machines under the guise of research. At a hearing, attorneys for the State Medical Society testified that they could find no authority in the Wisconsin Statutes for the chiropractic board to propose, much less adopt or enforce, such rules; and secondly, that if such authority existed in the board, the proposed rules would need very substantial revision for the protection of those people who would permit themselves to be objects of "chiropractic research."

Within the chiropractic profession itself a feud developed over the use of the questionable device.

(Continued on page 453)



THE CHIROPRACTIC NEUROLINOMETER, shown by Dr. William D. Stovall, is replete with dials, switches and lights. A metal disk is passed up and down over the spine and is claimed to detect nerve impingements. The Food and Drug Administration states that "the device is not capable of detecting and/or measuring any quantity of the body, that the bakelite plate is not capable of indicating any response from the Neurolinometer circuit, and that the device is worthless in the diagnosis of disease." At least 165 Neurolinometers have been distributed to chiropractors in 26 states, Canada, and New Zealand. The machine may be seen at the offices of the State Medical Society of Wisconsin, Madison.

FDA Seizes Two "Micros" In Wisconsin

A nationwide seizure campaign to stop the use of a fake diagnostic machine found in offices of hundreds of health practitioners, including Wisconsin, has been announced by the Food and Drug Administration.

The FDA said that about 25 Wisconsin chiropractors are thought to be among the 5,000 or more who paid $800 to $900 for the "Micro", as chiropractors call it. So far, two seizures have been made in Wisconsin—an Ellis Micro-Dynameter from A. T. *Bidgood*, a Juneau chiropractor, and another from Adolph *Lunde*, Stoughton.

The machine, known as the Micro-Dynameter, is supposed to be effective for detecting scores of serious diseases by measuring electric currents generated by metal plates applied to areas of the body. FDA scientists proved that the only condition measured by the device is the amount of perspiration on the skin of the patient.

FDA Commissioner George P. *Larrick* called the machine "a peril to public health because it cannot correctly diagnose any disease." He said "thousands of patients are being hoodwinked by its use into believing they have diseases which they do not have, or failing to get proper treatment for diseases they do have."

The seizure campaign follows a refusal by the United States Supreme Court June 11 to review a June, 1961, injunction against the Ellis Research Laboratories, Inc., and Robert W. Ellis, the president, of Chicago, in the Federal District Court at Chicago. The case was appealed on the grounds that the device was exempt from the Federal Food, Drug and Cosmetic Act because it was used only by licensed practitioners. The U. S. Court of Appeals at Chicago ruled that "under the findings of fact in the instant case, the Micro-Dynameter is not safe for use even in the hands of a licensed practitioner."

—Milwaukee Journal Photo

AN ELLIS MICRO-DYNAMETER was examined by Deputy Marshal Rodney J. Taubel after he seized the machine from a Juneau chiropractor.

NEUROLINOMETERS

(Continued from page 452)

While the Wisconsin Chiropractic Association defended its use, the Society of Wisconsin Chiropractors, Inc. joined the State Medical Society in opposing the proposed rules on the grounds that use of the "research model" has injured the profession by lowering public confidence in treatment methods.

PROFESSIONAL BUSINESS SERVICE

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WISCONSIN Agriculturist Farm Poll

Farm folks ponder medicare's merits

Do Wisconsin farmers agree with Sen. Alexander Wiley (Rep.) who voted to kill the Kennedy hospital insurance bill, or with Sen. William Proxmire (Dem.) who voted for it?

In mid-July, the U. S. Senate voted 52 to 48 to kill the bill. At almost the same time, the Wisconsin Agriculturist Farm Poll interviewed hundreds of Wisconsin farm people to see what they thought about the proposal.

Of the people interviewed, 44 percent had heard or read a good deal about the bill. And 51 percent had heard or read something about it. Only 5 percent hadn't heard or read about the bill.

The 95 percent who had heard about the bill were asked:

"If you have heard or read about this (Kennedy) hospital insurance plan, do you want Congress to pass it or to turn it down?"

This is what Wisconsin farm folks said:

	Men	Women	Total
Should approve	30%	24%	27%
Should turn down ..	45	38	41
Undecided	25	38	32

An earlier poll reported in July 1961, found farmers at that time inclined to favor a federal insurance plan. The question at that time was:

"Congress has been considering a plan to help people 65 or older pay their hospital and medical bills through expansion of the social security system."

Over 60 percent said, "Some plan of this kind should be adopted." Only 8 percent said, "Turn it down."

The bill that came to a vote in the Senate differed from earlier plans in that it dropped payment of medical bills.

Is the hospital insurance bill a party issue among Wisconsin farm people? This is the way Republicans and Democrats divide:

	Republicans	Democrats
Should approve	15%	37%
Should turn it down..	57	26
Undecided	28	37

What about the attitude of different age groups? President Kennedy seems to think that people in their old age and people in their middle years should especially favor the bill.

This is the way farm voters of different ages divided:

	Support	Turn down	Undecided
21-34 years ...	30%	46%	24%
35-49 years ...	32	42	26
50-64 years ...	33	50	17
65 and up	50	37	13

Older men, those 65 and up, gave the bill its greatest support with an approving vote of 58 percent. "It would be a good thing if it's run right," said an 80-year-old Barron county farmer.

"I believe the hospital plan is o.k.," said an older man in Waupaca county. "At the rates the doctors and hospitals charge a person can lose all they have in a short time and have nothing to live on if they recover."

While nearly all had heard or read something about the medical bill, many farm folks were confused on just what it would or would not have done.

"I think the older folks need medical help, but please explain the present plan to me," asked a Sawyer county woman.

"I was told that if the plan went into effect the people could not choose the doctor they want," an older widow in Wood county told the interviewer.

Actually, the final bill would have furnished money for hospitalization but would not have paid anything on doctor bills. So it would not affect the selection of a person's doctor.

We don't want more "government"

Some people objected to coverage of any people but the needy. "A lot of people over 65 don't need it. It would be a good idea to give it to those that need it," said a Crawford county widow over 65.

"I am in favor of this plan for the poor and unfortunate, but why pay for the rich who can well afford to pay their own?" said an older man in Dunn county.

A large number of the farm people were fearful of government stepping into the medical field. "Private insurance policies for hospitalization seem better. The government is top heavy now," said a Jackson county man.

"I think we should not provide hospital insurance through social security because we don't want socialized medicine. Just see what happened in Canada," a younger woman in Portage county told the poll taker.

"I know I sound like a Goldwater Republican, but I am a Democrat," said a Vernon county farmer. "I just believe people are better off without so much government interference."

Only one person interviewed said she was influenced by the opinion of the doctors. "The doctors don't want it so guess it's no good," said an Oconto county woman.

Some folks were apprehensive about the total amount that would have to be paid in added social security tax. A woman in Crawford county said, "I think it would be a burden to younger people paying social security tax."

Pre-Med Students Get Chance for Research at UW Medical School

Twenty pre-medical students at the University of Wisconsin had the opportunity this summer of working under a medical school professor on a research project of mutual interest. Comprising one-fifth of the medical school's prospective freshman class, the group was chosen on the basis of interest, academic record and enthusiasm.

Wisconsin has been a leader in introducing students to research while in medical school. This is the first year the University has given students a chance to do research before they begin their medical studies.

According to Harry A. Waisman, M.D., pediatrics professor and chairman of the medical student research committee, the University hopes that through this program "the students will acquire a critical view of what they read and study, a feeling for research, and a realization that they are but small cogs in a big research wheel."

Two-thirds of State Covered by Voluntary Health Insurance

Wisconsin is among 31 states which have more than two-thirds of their population protected by some form of voluntary health insurance, the Health Insurance Institute reports. As of the end of 1961 New York State had a coverage figure of 90.7 per cent based on more than 15.5 million insured residents. Only Alaska, New Mexico and Mississippi had less than 50 per cent coverage, with Alaska the lowest at 37.1 per cent.

SMS and Sen. Proxmire Exchange Views

While the State Medical Society of Wisconsin has been urging its members to let their senators and congressmen know their sentiments on proposed medicare legislation, it has officially carried on a lively correspondence with Senator William Proxmire. Reprinted here are the junior senator's answer to Doctor Fox's letter which commented on an address given to the National Federation of State, County and Municipal Employees and Doctor Fox's reply.

To: JAMES C. FOX, M.D.
Chairman of the Council

I very much appreciate your letter commenting upon my address to the National Federation of State, County and Municipal Employees.

My reference in the speech that was carried in the *Milwaukee Journal* on May 4 was to people over the age of 65. The latest figures show that over one-half of the people over the age of 65 living alone subsist on a yearly income of $1,000 or less. This means that a widow or widower or an unmarried man or woman in this category has to get by on less than $20 a week.

Over one-half of all married couples over the age of 65 have an income of less than $2,500 a year. This means that people in this group have a weekly income of less than $50.

During my trips to the State of Wisconsin I have talked to literally hundreds of people who are desperately ill. These people have told me that they do not have the money to get adequate medical attention. They are much too proud to go to welfare sources or to qualify under the means test set up by the Kerr–Mills Act. Wisconsin is a prosperous state. Other areas are not as blessed as our state. If this situation exists in Wisconsin, I feel sure that it is multiplied many times over in other areas.

I want to strongly emphasize my deep respect for the medical profession. It has done an outstanding job in handling the problems of the aged. There is much more to be done.

My father was a doctor. He practiced medicine for more than fifty years in the city of Lake Forest, Illinois. With this kind of background, I would be the last person to take a step which in my judgment would harm the medical profession.

WILLIAM PROXMIRE
United States Senator

To: THE HONORABLE WILLIAM PROXMIRE
United States Senator

I have taken the opportunity to discuss your reply to my letter of May 7 with a number of physicians, including the members of the Council and officers of the State Medical Society.

Statistics, as you know, are like Tinker Toys . . . . they can be put together in almost any shape. Your use of statistics does not take into account many matters of value to the elderly, such as family assistance.

Now you state you have talked to "hundreds of people who are desperately ill." This may be so, but we doubt seriously that they are denying themselves medical attention because of lack of funds. That they need not do so is a well established fact.

Physicians talk with the seriously ill and chronically ill daily throughout the length and breadth of Wisconsin. We have talked to them about the King–Anderson legislation, about the Kerr–Mills legislation and about voluntary health insurance. We have asked them whether they want to trade the kind of health care they are getting today for health care administered by federal government . . . whether they want to trade the atmosphere in which they now live for one which is supervised and governed by a paternalistic state.

We find them unwilling to make such an uneven exchange.

We regret that you did not sense this fact, as did the majority of your colleagues in defeating the Anderson–Javits amendments in the recent Senate vote, but we hope that the medical background of which you are understandably so proud will exert a more enlightening influence on your judgment of such legislation in the future.

JAMES C. FOX, M.D.
Chairman of the Council

State Commission on Aging Sets Hearings

The State Commission on Aging has announced that it will hold a series of local hearings in 24 Wisconsin communities.

"The hearings, to be held between September 18 and November 8, will have two main functions," Richard Bardwell, Commission chairman, pointed out. "They are to give Wisconsin's senior citizens an opportunity to relate their own actual problems to the Commission and to gather suggestions from interested local officials and senior citizens on ways these problems can be resolved on a local and state basis.

"Personal problems, whether they be employment, health, housing, lack of something meaningful to do, financial, or social are the things we are interested in hearing," Bardwell stated. "These first hand experiences will greatly aid the Commission in developing its future programs. As a newly created state agency, we feel a responsibility to find out what the people themselves are going through."

Bardwell also emphasized that interested public and private officials are invited to appear before the Commission to relate their ideas based on their work with the aging.

The hearings will be held in the following communities: Superior, Ashland, Rice Lake, Marinette, Rhinelander, Wausau, Wisconsin Rapids, Eau Claire, La Crosse, Fond du Lac, Oshkosh, Appleton, Green Bay, Manitowoc, Sheboygan, Baraboo, Platteville, Beloit, Janesville, Kenosha, Racine, Waukesha, Milwaukee and Madison.

Nurses to Meet in Milwaukee in November

"Preparing Today for Nursing Tomorrow" is the theme of the annual convention of the Wisconsin Nurses Association scheduled for November 7, 8 and 9 at the Hotel Schroeder, Milwaukee. Mrs. Margaret Dolan, president of the American Nurses Association, will be the keynote speaker.

The Office Nurses Section will meet the evening of November 7. "A Guide to the Practice of Office Nursing," a case study forum, will be moderated by Florence Kobus, R.N., Milwaukee, and will include Betty Turgai, R.N., South Milwaukee, and LaVerne Ladwin, R.N., and Betty Regan, R.N., both of Milwaukee.

On the same evening the Operating Room Nurses Conference Group and the Head Nurses Branch will hold a joint program meeting. Dr. Derward Lepley, Jr., assistant professor of surgery, Marquette University School of Medicine, will speak on "Cardiac Resuscitation."

Convention speakers will also include Dr. Mary Kelly Mullane, dean, College of Nursing, University of Iowa; Helen J. Weber, associate professor, Division of Nursing Education, University of Indiana; Helen Matheson, *Wisconsin State Journal;* and Dr. Edgar S. Gordon, professor of medicine, University Hospitals, Madison.

SHEBOYGAN MEDICAL SERVICE PRAISED

Sheboygan citizens, in a survey conducted by the Junior Chamber of Commerce, reported "very good" medical service as a major asset of their community.

With a total of 403 interviews, 55 per cent said medical service ranked in the top category, while 39 per cent said it was adequate, 5 per cent inadequate, and 1 per cent didn't know.

Figures for hospital and dental services were about the same.

WILLIAM T. CLARK, M.D.

State Health Board Reelects Dr. Clark

William T. Clark, M.D., Janesville, has been reelected as president, and J. S. Hollingsworth, D.D.S., Sheboygan, has been named vice-president of the State Board of Health, the state agency has announced.

Doctor Clark has served as president of the eight-man body since February, 1960. He has been a member of the board since 1943.

Doctor Hollingsworth, who has been a member of the board since April, 1954, became vice-president of the board in March of this year when he was elected to fill the vacancy created by the departure of Joseph C. Griffith, M.D., Milwaukee, whose term expired at that time.

VNS to Discontinue Rheumatic Fever Clinic at Madison

The Rheumatic Fever Clinic, administered by the Visiting Nurse Service at St. Mary's Hospital in Madison, will be discontinued after October 1.

Patient records are being returned to referring physicians and parents of the children are being advised to contact their family physicians for further treatment.

Physicians of patients formerly served by the clinic and in financial need may make application to the Bureau for Handicapped Children in Madison for inclusion in the Bicillin program.

Those wishing their patients to receive further clinic evaluation may contact Thomas Meyer, M.D., at the University of Wisconsin Medical School, department of pediatrics. A clinic is being established there on a fee-for-services basis.

NURSING SCHOLARSHIPS AWARDED

Two $400 nursing scholarships have been awarded by the Sauk County Medical Society. Funds for the scholarship work come from fees paid to doctors who aid in the county's immunization program and then contribute the fees to the scholarship budget.

BOWLING TOURNAMENT

Plans are being arranged for a physicians' bowling tournament. Watch for details later.

TRANSACTIONS OF 1962 REGULAR SESSION HOUSE OF DELEGATES

State Medical Society of Wisconsin

MAY 7, 8 and 9, 1962

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TRANSACTIONS OF 1962 REGULAR SESSION, HOUSE OF DELEGATES

State Medical Society of Wisconsin
May 7, 8 and 9, 1962

The 121st annual meeting of the House of Delegates of the State Medical Society of Wisconsin was held at the Milwaukee Auditorium, Milwaukee, Wisconsin, on May 7, 8 and 9, 1962. Dr. Robert E. Callan, Speaker of the House of Delegates, presided.

Presented below are reports submitted to the House, the recommendations by reference committees and the House actions.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

J. F. Walsh, M. D., Port Washington
Chairman
L. W. Schrank, M. D., Waupun
J. V. Bolger, M. D., Waukesha
H. F. Twelmeyer, M. D., Milwaukee
F. M. Hilpert, M. D., Racine

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

F. E. Gehin, M. D., Stevens Point
Chairman
G. W. Hilliard, M. D., Milwaukee
W. T. Russell, M. D., Sun Prairie
H. G. E. Mallow, M. D., Fort Atkinson
J. E. Martin, M. D., Delavan

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Edgar End, M. D., Wauwatosa
Chairman
C. J. Picard, M. D., Superior
R. G. Zach, M. D., Monroe
C. J. Strang, M. D., Barron
E. P. Rohde, M. D. Galesville

●

MINUTES OF 1961 SESSION OF HOUSE

The entire proceedings of the 1961 regular session of the House were printed in the September, 1961, issue of the *Wisconsin Medical Journal.*

HOUSE OF DELEGATES ACTION—Approved as printed.

●

REPORT OF PRESIDENT—1961–1962

Leif H. Lokvam, M. D., Kenosha

It has always been pleasant employment to come together with you, my colleagues, to join in common effort dedicated to the health needs of all the people in our State of Wisconsin.

You have seen quite enough of me over the past years—years which have been a gratifying experience.

The problems and achievements of the past year are assessed by you at this convention, and we seek here also a vision for the future.

Thank you for allowing me to serve you. Thank you for your efforts, good will and friendship.

We hope for Doctor Hill and the officers and staff your continued support for the high purposes to which we all aspire, and the honor of our profession which we all cherish.

My charge to you is that you continue steadfast in your primary concern, that of serving your patients, serving the public in day-by-day service, and in so doing nothing can prevail against you.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the President's report. It complimented the devoted service of Doctor Lokvam on behalf of the membership.

HOUSE OF DELEGATES ACTION—Adopted the report of the President as recommended by the Reference Committee.

●

REPORT OF PRESIDENT-ELECT—1961–1962

Nels A. Hill, M. D., Madison

The report of the President-elect was printed in the June, 1962, issue of the *Wisconsin Medical Journal.*

Under the provisions of the Bylaws, the President-elect appointed the following standing committee members where terms expired or vacancies occurred:

COMMITTEE ON CANCER

R. C. Frank, M. D., Eau Claire
G. I. Uhrich, M. D., La Crosse
R. C. Glise, M. D., Richland Center
G. A. Smiley, M. D., Delavan
J. J. Gramling, Jr., M. D., Milwaukee
J. F. Brown, M. D., Rhinelander
(all reappointments)
Paul Cunningham, M. D., Appleton, reappointed chairman

COMMITTEE ON GRIEVANCES

E. D. Sorenson, M. D., Elkhorn
E. W. Mason, M. D., Milwaukee
R. W. Mason, M. D., Marshfield
(all reappointments)
E. D. Sorenson, M. D., reappointed chairman

COMMISSION ON PUBLIC POLICY

R. G. Zach, M. D., Monroe
H. E. Oppert, M. D., Viroqua
E. C. Quackenbush, M. D., Hartford
(all reappointments)
R. G. Zach, M. D., reappointed chairman
J. F. McIntosh, M. D., Madison, appointed vice-chairman

COMMISSION ON SCIENTIFIC MEDICINE

J. K. Curtis, M. D., Madison

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

R. S. Gearhart, M. D., Madison
T. H. McDonell, M. D., Waukesha

M. V. OVERMAN, M. D., Neillsville
(all reappointments)
R. S. GEARHART, M. D., reappointed chairman

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

C. J. PICARD, M. D., Superior
D. G. MACMILLAN, M. D., Barron
W. E. ACHESON, M. D., Valders
(all reappointments)
R. J. BOTHAM, M. D., Madison
(appointment to fill unexpired term of G. M. Shinners, M. D., who resigned because of pressures from other commitments)
D. E. DORCHESTER, M. D., Sturgeon Bay, reappointed chairman

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of President-elect's report, including committee appointments.

HOUSE OF DELEGATES ACTION—Adopted the report of the President-elect as recommended by the Reference Committee and approved the committee appointments.

REPORT OF COUNCIL—1961–1962

James C. Fox, M. D., La Crosse, Chairman

Regular meetings of the Council are held quarterly, and in 1961 there were two additional special meetings. There will be a further meeting of the Council just preceding the Annual Meeting.

Quackery

Many substantial actions have been taken by the Council since the last meeting of the House. An active educational program in the area of cancer quackery is being undertaken and will be initiated with a Wisconsin Conference on Quackery to be held as soon as detailed arrangements can be made. Other areas approved by the Council include a review of Wisconsin laws, the development of portable exhibits, a restudy of the basic science laws, and a determination of whether some programs on quackery can be offered in the medical schools.

Chiropractic "Research" Rules

Another important step was to authorize the Society's legal counsel to oppose the proposition that the State Board of Examiners in Chiropractic could license chiropractic research. This smacked too much of the "black box."

The proposed rules were rejected by the chiropractic board after a hearing on the subject.

Statement on Conflict of Interest Approved

Several matters should be specially directed to the attention of the delegates. One of these relates to conflict of interest precautions in the area of insurance operations. The Insurance Commissioner now requires of all members of boards of directors of insurance programs, and staff members holding responsible positions, the reporting of any possible conflict of interest in the operation of the program; and to that end the statement which follows has been circulated to councilors, officers, members of the Commission on Medical Care Plans and staff, and (with few exceptions at this writing) each has acknowledged its receipt and signed the statement requested:

"*Resolved*, That the Council hereby adopts the following formal Statement of Policy on Conflict of Interest, for application to all councilors, officers, members of the Commission on Medical Care Plans and employees in responsible positions:

"Beginning with the WPS Annual Statement for the calendar year 1961, which the Com-

TREATMENT OF BURNS IN A PRIVATE GENERAL HOSPITAL, Drs. George Collentine, John Canway, Burton Waisbren, and W. J. Wolaschek, St. Mary's Hospital, Milwaukee. By use of slides and illustrations the exhibit described facilities, patients, techniques, and results of treating burns at a specialized center—second place winner, Smaller Hospitals and Individuals class, scientific exhibits.

missioner of Insurance of Wisconsin requires be filed with him by March 1, 1962, the Society must indicate the establishment of a procedure for disclosure to the Council of any material interest on the part of all councilors, officers, members of the Commission on Medical Care Plans and responsible employees which is in conflict with or is likely to conflict with the official duties of such person.

"As a basis for such procedure, the Society wishes to remind you that your relationship calls for a standard of undivided loyalty to the Society at all times. As you know, you serve the Society in a representative or fiduciary capacity.

"You must at all times not only further the Society's interests, but also avoid placing yourself in a position where your personal interests are or may be in conflict with your duty to the Society. It is not the purpose of this Statement of Policy to serve as a catalog of instances that might give rise to conflicts of interest. In general, you should avoid, directly or indirectly, participating in any arrangement, agreement, investment or other activity which could result in personal benefit at the expense of the Society's interests. You should also refrain, as should members of your family, from accepting gifts or other favors under circumstances from which it might be inferred that the gift was intended to influence you in the performance of your duties for the Society.

"*Resolved Further*, That with respect to implementing such formal Statement of Policy, the Council hereby approves and adopts the following procedure:

"1. A copy of the Statement of Policy on Conflict of Interest, together with a statement for individual signature, shall be circulated by the Secretary to each councilor, officer, member of Commission on Medical Care Plans and to all employees in responsible positions. Such statement shall make provision for disclosure of any present conflict of interest and include a requirement to report any future situation creating a possible conflict of interest.

"2. The individual statement shall be completed and returned within 15 days to the Secretary of the Society for his review and report.

"3. There shall be put on the agenda of each annual meeting of the Council the report of the Secretary and a review of the corporate procedure with respect to conflict of interest.

"*Be it Finally Resolved*, That the purpose of this statement is to clarify this policy for the guidance of all concerned, bearing in mind that legally and morally it is the continuing duty of all employees and agents of the Society to represent and promote the best interests of the Society.

"Instances in which a conflict of interest situation might arise as to a councilor, officer, commissioner or employee include:

"(a) A financial interest by any such person, or a member of his immediate family, in a competing insurance organization, or any other concern doing business with the Society, unless such aggregate family interest is less than ten per cent (10%) of the equity in such concern.

"(b) Serving as a member of the board of a corporation, including a county or other medical society, which owns or operates a prepayment sickness care plan, whether on a profit or nonprofit basis, whether for direct, indirect or no compensation.

"(c) Rendition by any such person of directive, managerial, advisory or consulting services to a competing organization or prepayment plan, or any outside concern doing business with the Society, or the acceptance of any outside employment that would be likely to conflict or interfere with his duty to the Society, except with the full knowledge and formal consent of the Society.

"(d) Disclosure or use of confidential Society information for personal advantage of any such person or anyone else.

"(e) Acceptance by any such person or a member of his immediate family of gifts of more than token value, excessive or lavish entertainment, or other substantial favors from any outside source which could be construed as influencing or attempting to influence the performance by any such person of his proper duty to the Society."

Regional Staff Assistants

One of the more important administrative decisions has been to provide certain areas of the state with regional staff employees who will implement the component county medical societies in various of their undertakings. It is felt that more realistic work can be done by staff members residing in these areas who are readily available to "trouble shoot" such situations as a community suddenly and unexpectedly deprived of medical services; the clarification of problems of patients, particularly as to the availability of physicians; active liaison with hospital-physician staffs; and public relations projects of the local medical community.

This program will necessarily start slowly as a very considerable amount of training is needed so that these men might be of the maximum service to the various areas of the state. The first regional position has been established at Eau Claire, the position filled, and the employee now in training. This area will extend down to La Crosse and up to Superior, and cover the general vicinity of Eau Claire. Two other regional positions will be established in the central part of the state and in the Fox River Valley. The staff will be fortunate to fill vacancies and have the operation in full swing by the year end.

New Programs of Public Information

Beginning early in 1963, a program of public cooperation and information will be instituted in the headquarters of the State Medical Society, where a meeting facility for upwards of 200 is being incorporated in the addition until such time as it may become needed for other purposes. In the planning stages are institutes for hospital administrators and chiefs of staff, periodic conferences on internships and residencies, annual visitation of medical students, interprofessional programs, and many others of similar character which will bring meetings to the headquarters of the State Medical Society rather than take officers and staff to meetings held in other locations. It is felt that in the careful planning of this project certain expenses now encountered in bulletins, in regional meetings, and in travel can be eliminated to the point that the annual cost of this meeting facility to the Society dues structure of about $8,000, and to its Blue Shield plan of the same amount, will be substantially offset.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of this portion of the report. It directed the attention of the House to the fact that the State Medical Society has complied with the requirement of the Wisconsin Insurance Commissioner concerning conflict of interest. It further recommended individual support of AMPAC and WISPAC.

HOUSE OF DELEGATES ACTION—Adopted this portion of the Council report as recommended by the Reference Committee.

Report of Council—continued

Amendments to the Bylaws

After consideration by the Council and its committees, the following bylaw amendments are recommended to the House of Delegates:

(1) Add to Chapter VII, Section 1, on standing committees:

"The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member."

(2) Amend Chapter VI, Section 7, as follows:

"The Council *may*, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

(Add the following:)

"When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX."

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of item (1), amendment to Chapter VII, Section 1, on standing committees, as presented, and item (2), amendment to Chapter VI, Section 7, without change, in that portion of the Council report relating to amendments to the Bylaws.

HOUSE OF DELEGATES ACTION—Adopted the amendments to the Bylaws as recommended by the Reference Committee.

Report of Council—continued

(3) Amend Chapter XI, as follows:

Delete in its entirety the fourth paragraph, Section 3, Chapter XI, of the Bylaws, which reads:

"A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed."

Add a new second paragraph to Section 6 of Chapter XI to read:

"When a member in good standing in a component society removes his principal practice outside the borders of this state, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this state shall cease upon his acceptance by a society in the new area of practice and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice."

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended acceptance of item (3), amendment to Chapter XI, in that portion of the Council report relating to amendments to the Bylaws, but in the following revised form:

Amend the fourth paragraph of Chapter XI, Section 3 of the Bylaws to read:

"A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed."

And add a new second paragraph to Chapter XI, Section 6, to read:

"When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice."

HOUSE OF DELEGATES ACTION—Adopted this portion of the report as amended by the Reference Committee.

Report of Council—continued

The Washington Scene

As Chairman of the Council I should like to express my own personal feeling that every physician must be concerned with the nationalizing influence of medical legislation. In the past several decades the tendency to look to the "Great White Father" in Washington has brought about an increasing amount of federal legislation offered as a panacea to cure the ills and meet the hopes of those who are proclaimed as America's suffering citizens.

Governmental paternalism at the local level is carefully weighed in light of considered needs of the people of the community. These considerations become the more remote at the state level, but when they become the province of federal legislation under its mechanism of grants-in-aid, whole areas of welfare programs can be enacted, not precisely trimmed to what may be a lesser need in some areas, or no need at all in others. The administrative tendency under these circumstances is to hunt and find and endeavor to qualify people for the largess of the federal government who, left on their own, might well find ample help at home and without measurable effect upon the governmental health structure.

We have been much concerned with state legislation and, indeed, it has perhaps monopolized our thinking out of proportion to its importance. The

Council and officers, and the officers of county medical societies, have had opportunity in the last few months to meet in the headquarters of our national organization, and I urge upon all physicians in this state, and to the extent I have influence in other states, to find the occasion to visit the American Medical Association.

There is brought home to us vividly and effectively that the science of medicine and our ability to practice it as best we know how cannot be divorced from the economics of our country and its legislative halls.

And AMPAC

All of us know of AMPAC as an arm of the medical profession to serve not only in political action but in widespread educational efforts as to the effects of proposed legislation.

The Council has approved AMPAC and its objectives. It urges cooperation by Wisconsin physicians. And as Chairman of the Council I add my most emphatic endorsement as well. The medical profession in the last two decades has learned that it must speak out. Here is an opportunity to do so, and effectively.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of this portion of the report.

HOUSE OF DELEGATES ACTION—Adopted this portion of the Council report as recommended by the Reference Committee.

●

SUPPLEMENTARY REPORT OF COUNCIL 1961–1962

James C. Fox, M. D., La Crosse, Chairman

The Council of the State Medical Society holds regular meetings on a quarterly basis and special meetings as required. Its Executive Committee meets monthly in the interim between regular Council meetings and its committees on Finance, Scientific Medicine, Planning, and Economic Medicine meet periodically during the year. These several committees generally have opportunity to review matters later to come before the full Council. During the past week end, there were meetings of the committees on Finance, on Economic Medicine, and the Executive Committee, and on Sunday afternoon and into the evening a full meeting of the Council. The Committee on Scientific Medicine will be in session before the Annual Meeting is concluded.

I shall highlight the more important of a number of actions taken.

The Council felt it important to coordinate a health study of our new county of Menominee. It has asked the Foundation of the Society to implement physician direction of such a study, and the Foundation will seek assistance of welfare and other agencies as well. The membership will be advised of developments from time to time in reference to this matter.

Several resolutions are being forwarded to the House through this report. They speak for themselves and you will have copies of them, of course.

Hospital Pharmacies

The Council is concerned with the broad subject of pharmacy regulations as they affect medical care in the hospital.

This subject is an important and a complex one which needs further study and very likely joint consideration with representatives of the hospital associations of the state and with the State Pharmacy Board. When the matter has been adequately surveyed and considered, a statement will be prepared for the joint assistance of professional staffs and governing bodies of the hospitals of the state. It is believed that such a statement could do much to clear any confusion and uncertainties which may now exist.

The subject of hospital pharmacies has several facets. The first is the necessity of protection of the patient. The second is recognition of the shortage of professional pharmacists or the impracticability of their employment in some small hospitals. A third is the continuing responsibility of the physicians who comprise the professional staff of the hospital. A fourth is the complication presented as an increasing number of dentists are admitted to qualified staff privileges in an increasing number of hospitals of the state. A fifth is the position of the nursing and other staffs of the hospital with reference to hospital pharmacies and the administration of drugs. Sixth, it is important from the standpoint of hospital administration and the time and convenience of physicians that no administrative body propose or seek to enforce unrealistic or unnecessarily cumbersome rules with reference to hospital pharmacies. Finally, each of these factors should be considered in light of the economic implications to the patient.

The following basic considerations are believed to underlie the subject of hospital pharmacies:

(1) It is the duty of each physician and hospital medical staff to be responsible, individually and collectively, for the proper establishment of adequate staff rules relating to the storage, safe handling and usage of drugs in a hospital, and to assure their continued enforcement.

(2) The attention of the members of the State Medical Society is directed to the necessity for the development of adequate procedures to safeguard the administration of drugs to their patients. This should include designation by the medical staff and hospital administration of authority and responsibility for the proper handling of drugs. It should also include designation of responsible individuals to service the drug needs of patients in those hospitals where no pharmacists are available, and in other hospitals at times when their regular hospital pharmacists are not available on a 24-hour basis.

It gives me real pleasure to tell you that the Council yesterday affirmed the recommendation of the Commission on Hospital Relations and Medical Education that the Hayward Area Community Hospital receive the citation of this Society for its achievements and its service. Hayward is in the northwestern part of the state. While the Mississippi Valley, where the chairman of the Council resides, is famed for its scenic and recreational facilities, so does Hayward enjoy the fame of being the Muskie Capital of the world. Here is a fine demonstration of a community working together to promote its well-being in many senses of the word, and I am happy that its hospital has achieved this recognition.

RECOMMENDATIONS OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended to the committee to be appointed by the Foundation that it consider coordinating the activities of those wishing to volunteer in meeting the health needs in Menominee County. Extensive discussion of the Council's recommendations concerning hospital pharmacies met with the complete approval of the Reference Committee. The Reference Committee acknowledged the selection of the Hayward Area Community Hospital for the Hospital Achievement Award.

HOUSE OF DELEGATES ACTION—Adopted this portion of the supplementary Council report as recommended by the Reference Committee.

Supplementary report of Council—continued

At this time it would be appropriate for me to comment in another vein of praise. The Chairman of the Council on Medical Service of the American Medical Association is John Flack Burton, M. D., of Oklahoma City. He has written to the State Medical Society pointing out that the structure of the Council has six committees, one of them being that on Insurance and Prepayment Plans, of which Robert L. Novy, M. D., of Detroit, is chairman. Doctor Burton said in his letter that the Council finds that physicians serving on these national committees, devoting a great deal of time and energy in working for their profession, often do so without appreciation by the state association of their contributions. He asked that the services of one of our Wisconsin physicians be brought to the attention of the House of Delegates and officers of the Society. He refers to Ervin L. (Sarah) Bernhart, M. D., of Milwaukee, who is a member of the insurance committee. Doctor Burton comments that "AMA councils and committees rely heavily on the gratuitous service given by such men as Doctor Bernhart, and it is hoped that during your forthcoming meeting, the Council's sincere expression of appreciation for his acceptance of this responsibility can be relayed to the officers and members of the State Medical Society."

Now among other things, the Council yesterday received a consolidated financial statement from the Society's certified public accountants, Donald E. Gill & Co. of Madison. This is a comprehensive report and you will wish to consider it along with the report of the treasurer, Doctor Weston, which will be made in a short time.

Letter from

DONALD E. GILL & COMPANY

May 1, 1962

To the Council of the State
Medical Society of Wisconsin

Gentlemen:

Attached is a tabulation showing Financial Condition and Income and Expenditures of the State Medical Society of Wisconsin and its related activities. Financial condition is shown as of December 31, 1961. Income and expenditures are those for the year ended December 31, 1961, with the exception of the Charitable, Educational and Scientific Foundation. In that case income and expenditures for the six months ended December 31, 1961 are shown. The Foundation's fiscal year ended June 30, 1961.

The information shown, with the exception of that for the Foundation, is taken from our audit reports for the year ended December 31, 1961. Information on the Foundation was supplied to us by the Society's Accounting Department. We made analyses of accounts and transactions of the Foundation for the six-month period ended December 31, 1961, but have not made an audit for this period. We have audited the records of the Foundation at June 30, 1961.

Certain footnotes and contingent liabilities which are a part of statements in our audit reports are incorporated in this report by reference. As you know, detailed information on each of these activities is presented to, and reviewed by, appropriate committees or boards of the Society.

In the attached tabulation inter-activity receivables and payables included in assets and liabilities,

FETAL ELECTROCARDIOGRAPHY, Drs. Jack A. Klieger and Richard Mattingly, St. Joseph's Hospital, Milwaukee, and the Department of Obstetrics and Gynecology, Marquette University Schaal of Medicine; and S. D. Larks, Ph.D., Department of Bia-Physics, Marquette University Schaal af Engineering. The exhibit contained reproductians af actual fetal electrocardiogroms indicating such things as early diagnasis of pregnancy, multiple pregnancies, cangenital heart disease and fetal distress. A recarder in the exhibit transcribed instantly a fetal electracardiagram taken on a pregnant patient at St. Joseph's Haspitol. Doctar Larks is shawn above laaking aver the exhibit—third place winner in Larger Hospitals and Universities class, scientific exhibits.

and itemized in our separate audit reports, are not eliminated. Also, employer and employee contributions to the Pension Plan, which totaled in 1961 $25,327.85, are treated not as income but as additions to principal of the Plan.

This information is supplied to you in accordance with a recommendation of the Reference Committee on Reports of Officers to the 1960 session of the House of Delegates, duly adopted.

Respectfully submitted,
/s/ DONALD E. GILL & COMPANY
Certified Public Accountants

(See following page for Statement of Financial Condition.)

I wish now to direct your attention to the fact that sections of the Society may be formally organized under Chapter XIII of the Bylaws. The procedure is that the request for organization comes to the Council which, if it approves, forwards the recommendation to the House of Delegates for ratification. There are more than 40 dermatologists in the state. They seek specialty recognition under the provisions of Chapter XIII, and the Council recommends to the House that this recognition be extended.

Yesterday the Council received a statement from the Commission on Medical Care Plans relative to the further progress of voluntary insurance programs and, in particular, reference to the matter of "nationalizing" programs for employers having their employees residing in a number of states. The Council accepted the statement which follows.

Statement of Commission on Medical Care Plans

In the further progress of voluntary insurance programs for the aged and for groups defined as "national," that is, having a common employer but residing in a number of states, there are those who are proponents of a plan which involves basically three major elements:

1. A uniform contract;
2. A uniform premium or rate charge; and
3. An identical schedule of surgical and medical benefits, with the amounts, perhaps, being determined locally.

State Medical Society of Wisconsin
Madison, Wisconsin

Financial and Operating Data on the Society and its Related Activities
at December 31, 1961 and the Year Ended That Date, Except as Noted

	S.M.S. General Fund	W.M.J.	W.P.S.	Medicare	S.M.S. Realty Corp.	Pension Plan	Foundation
Financial Condition - December 31, 1961							
ASSETS							
Current	$ 78 065 06	$21 992 78	$4 150 804 47	$140 564 46	$ 55 175 86	$124 762 58	$118 011 56
Fixed (Net)	27 677 87	712 03	458 187 79		415 986 56		151 409 47
Other	11 325 26	798 33	33 231 16		3 949 48	41 67	20 905 58
TOTAL	$117 068 19	$23 503 14	$4 642 223 42	$140 564 46	$475 111 90	$124 804 25	$290 326 61
LIABILITIES, RESERVES AND CAPITAL							
Current	$ 21 751 07	$ 5 148 75	$1 448 883 41	$ 80 564 56	$ 21 768 55	$ 283 21	$ 21 420 47
Fixed		18 354 39		60 000 00	257 500 00		35 000 00
Deferred Income	14 339 50		1 176 588 18				
TOTAL LIABILITIES	$ 36 090 57	$23 503 14	$2 625 471 59	$140 564 56	$279 268 55	$ 283 21	$ 56 420 47
Reserves and Special Capital			2 016 751 83		50 749 23	124 521 04	233 906 14
Current Surplus and Donated Capital	80 977 62				145 094 12		
TOTAL	$117 068 19	$23 503 14	$4 642 223 42	$140 564 56	$475 111 90	$124 804 25	$290 326 61
Income and Expenditures - Year Ended December 31, 1961 Except for Foundation Which is for Period July 1, 1961 to December 31, 1961							
INCOME							
Dues	$250 570 25	$	$	$	$	$	$
Premiums			9 707 643 23				
Other	30 351 73	55 038 32	114 719 82	25 297 35	131 796 35	3 607 83	23 330 62
TOTAL	$280 921 98	$55 038 32	$9 822 363 05	$ 25 297 35	$131 796 35	$ 3 607 83	$ 23 330 62
EXPENDITURES							
Benefits	$	$	$8 094 626 94	$	$	$	$
Administration	296 083 05	54 387 35	1 128 708 54	25 297 35	120 251 23	1 016 64	9 789 98
TOTAL	$296 083 05	$54 387 35	$9 223 335 48	$ 25 297 35	$120 251 23	$ 1 016 64	$ 9 789 98
Excess-Income Over Expenditures	($ 15 161 07)	$ 650 97	$ 599 027 57	$	$ 11 545 12	$ 2 591 19	$ 13 540 64
Less: Transfers to Special Surplus Accounts	(8 754 40)				9 499 76		
Transfer to Security Valuation Account			36 933 93				
BALANCE	($ 6 406 67)	$ 650 97	$ 562 093 64	$	$ 2 045 36	$ 2 591 19	$ 13 540 64

( ) Denotes Red Figure

REFERENCE COMMITTEE ON REPORTS OF OFFICERS. Drs. F. M. Hilpert, Racine; J. F. Walsh, Port Washington, chairman; H. F. Twelmeyer, Milwaukee; and J. V. Bolger, Waukesha. Dr. L. W. Schank, Waupun, also was a member of the committee.

Inherent in this type of programming is a pooling of the income from subscribers and its disbursement according to the precise schedule applicable in each area. While the advantages in the development of such a program cannot be denied, still there are certain difficult spots which bear careful consideration in the interest of the health needs of the people.

A national contract of this character does assume that health conditions and problems are uniform throughout the country and fails to take into consideration that they do vary somewhat by geographic and racial characteristics within specified areas.

A national program tends to and may defeat local programs.

The health care of any segment of American population always seems to be best handled when considerations and responsibilities are at the local level. This has been pretty much characteristic of the Wisconsin programs for the administration of health care to the needy and it is a position that the State Medical Society has supported from time to time in the past.

Here in Wisconsin the State Medical Society has promoted a program for the care of the senior citizens known as the "Century Plan," especially designed and tailor-made for their needs. There is an element of those people, however, which feels that the $9.00 a month cost of this voluntary program is beyond their reach. But understanding that most of these are not in a category of public assistance or relief cases, then it follows that implementation of the Kerr-Mills bill would substantially alleviate if not entirely wipe out that problem.

There may be areas of the country where the population is small and where a grouping of areas may be indicated in the health interest of the people.

We will cooperate in nationally developed programs for the care of the aged, but at the same time we do not believe that we should submerge the identity of our excellent plan in light of one which cannot take into account the special needs and wishes of our people. We feel also that costs of insurance based upon local experience promotes protection against an unnecessary rise in costs of health care services.

The problem of the national account is not an easy one to solve, for the decision to purchase a "national plan" may be made in some area far from Wisconsin and where the Wisconsin population of its employees is not of major consideration. But here Wisconsin has an answer in that it provides full payment, within contract benefits and within a maximum liability, for the usual, customary and reasonable costs of physicians' services. Whether a national account determines upon this plan, or relates some income level to its program, still the concept of paying a physician a reasonable fee is one which is practicable, has been demonstrated as workable, and has been acknowledged as successful.

To engage in a national account program for varying defined income levels is at complete odds with the program of paying reasonable, customary and usual fees, and focuses so much attention upon the inequities in contract coverage that the long-range purpose of voluntary insurance as one intended to meet the complete and unpredictable health costs of the people is overlooked.

For the present, the Commission on Medical Care Plans does not care to recommend, therefore, any commitment to relative fee schedules or national contracts which require varying levels of income as determinative of eligibility for full payment.

In other action the Council reelected the chairman, vice-chairman and division heads of the Commission on State Departments, and I would be remiss if I did not tell you of the deep appreciation of the Council and Officers for the splendid work of this group of physicians. You know of the duties of the Commission because they are in the delegates' handbook through the presentation of resolutions and reports. But as a personal comment I would like to emphasize that 99 physicians serve cooperatively in the committee structure of this Commission, and that those physicians reside in virtually every nook and corner of Wisconsin; often drive many miles to participate in the responsibilities of our profession; and to them as well as to all committee members of the State Society may I express for myself and for my fellow councilors our deep appreciation.

Other matters were reviewed by the Council and they will be related to you in due course. I want to devote the rest of this report to one of the major activities undertaken yesterday.

Undoubtedly the most urgent matter before all physicians at the moment concerns our national

legislative situation. An intensive campaign is building around President Kennedy's address to a mass meeting of senior citizens in Madison Square Garden on Sunday, May 20. The American Medical Association is planning a nationally televised response the next evening by AMA President Leonard Larson and Doctor Edward Annis.

The AMA and others believe that the period immediately following the May 20 address of the President will be crucial in the determination of the pattern of health care in this country. In recognition that the doctors of Wisconsin must do their part and do it well, the Council has authorized a statewide public information program to urge the public to listen to both of these important addresses and then to express their opinions to their Senators, Congressmen, personal physicians and the State Medical Society.

Each councilor and officer has volunteered to conduct personal letter-writing contacts with prominent individuals of their social, professional and business acquaintance. We sincerely hope that each of *you* will follow this example by urging your friends to immediately express their opinions to their Congressmen, and to enlist their acquaintances in the same kind of effort.

The Council is extremely pleased with the widespread efforts of the profession to inform the public on these issues. The tri-county society at Ashland held a highly successful public forum. In the Rice Lake area the physicians have staged a series of radio interviews. The county societies in Brown, Fond du Lac, Crawford, and many others have undertaken impressive educational programs through advertising and newspaper articles. These are but a few of the determined efforts of our membership to reveal to the public the true hidden dangers of King–Anderson legislation . . . government interference with the patient and doctor relationship.

Those who have not appreciated the fundamental dangers of King-Anderson-type legislation will certainly do so in reflecting upon Senator Proxmire's statement to a convention here in Milwaukee a few days ago. I think his remarks so reprehensible that I should read in full the text of our letter to him today:

"Dear Senator Proxmire:

"A Milwaukee newspaper states that in your May 3 address to the National Federation of State, County and Municipal Employees, you said: 'Hundreds of thousands of Americans are dying because they can't afford to live.'

"This is not the truth and you know it.

"The fact is that millions of Americans are living in unprecedented good health because of the high quality of American medical care.

"Certainly you must be aware that basic health care is already available to those who need and want it.

"Your views illustrate why we of the medical profession urge continuation of our present excellent system rather than development of a system which has a history of producing poor health care.

"We believe human dignity and health can best be preserved by the system that has brought it to its present unassailable point of success, instead of substituting a system which puts health care at the mercy of political demagogues.

"On behalf of the thirty-five councilors and officers of the State Medical Society, I respectfully submit this letter for your consideration.

(signed) JAMES C. FOX, M. D.
Chairman of the Council"

The present crisis which jeopardizes the future progress of health care of our citizens should not stand in the way, however, of further very basic programs to demonstrate other positive achievements of the profession. In the final analysis, the achievements of the profession rest in the individual doctor of medicine. Our 50 year club awards are but one example of many which need to be developed to honor those among our membership who have rendered outstanding service to their profession and their communities. Only with full public recognition of such service can the image of the profession be personalized and come to have new meaning for the public.

Finally, the Council recalls with pride the endorsement that it gave to the establishment of the American Medical Political Action Committee (AMPAC). It is a pleasure to report that interested physicians in Wisconsin have followed the national pattern with the activation of WISPAC . . . the Wisconsin Professional Political Action Committee. I urge each of you and your fellow practitioners to support this essential civic and political activity with your contributions, your time, and your personal interest.

Resolution Condemning the Proposed King–Anderson Legislation

WHEREAS, The method of financing the proposed King-Anderson Legislation (H. R. 4222 and S. 909, 87th Congress) would be through an economically unrealistic and actuarily unsound Social Security taxation system, and

WHEREAS, Federal Administration attempts, supported by pressure groups, to demonstrate widespread medical indigency of the aged have not been substantiated by fact, and

WHEREAS, Reliance on Federal Government for personal needs is contrary to basic American principles and leads to the unhealthy dependency status of the individual, which is fundamental to socialism, and

WHEREAS, The vital patient-physician relationship and the high quality medical care, now enjoyed, would be seriously injured by regimentation and bureaucratic controls, and

WHEREAS, Rapidly expanding prepaid health care plans for the aged coupled with Kerr-Mills assistance for those whose immediate resources are insufficient to meet their current health care needs is the most economic and effective method of assuring health care to all who need and want it, therefore be it

Resolved, That the Council of the State Medical Society of Wisconsin, in regular session assembled in Milwaukee, Wisconsin this 6th day of May, 1962 condemns the proposed King-Anderson Legislation as not in the best interests of the people of the State of Wisconsin or the United States of America, and be it further

Resolved, That the President of the United States of America be notified of this action, and be it further

Resolved, That both United States Senators and each member of the United States House of Representatives from the State of Wisconsin be sent a copy of this Resolution.

Resolution

WHEREAS, The 3rd Annual Conference of Presidents and Secretaries of Component County Medical Societies in Wisconsin was held at the headquarters of the American Medical Association in Chicago on March 16, and

WHEREAS, Reaction from the county society officers who attended was uniformly high in praise of

AMA's leadership and programs with such comments as:

. . . "A one day meeting like this is just right . . . very worth-while."
. . . "The greatness (excellence) of AMA needs to be brought home to us every year."
. . . "I was most impressed with AMA."
. . . "It would be well for every county society officer to attend at least one such conference annually."
. . . "Enlightening and stimulating . . . an experience to engender pride in any AMA member."

Now, therefore, be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin express its appreciation to the American Medical Association for a most outstanding presentation of the scientific, socio-economic and public relations programs being carried out through the Association; and be it further

Resolved, That copies of this resolution be sent to all state medical associations as a means of encouraging all members of the AMA to visit their national headquarters at the earliest opportunity.

Resolution Regarding Pathology

WHEREAS, The practice of pathology, both clinical and anatomical, has been declared repeatedly to be the practice of medicine by the American Medical Association, by the State Medical Society of Wisconsin, by other state and county medical societies, by the College of American Pathologists, and other special professional societies, by the courts of record having certain legal jurisdictions, and by opinions or record of attorneys general of certain states; and

WHEREAS, There are medical laboratory technicians and other non-professional persons operating independent medical lahoratories on a commercial basis without medical licensure, without adequate education or training, and without proper professional supervision; and

WHEREAS, Persons operating such commercial laboratories are not constrained by law or by their education and training to adhere to professional ethical principles guarding the public interest; and

WHEREAS, Such commercial laboratories frequently charge fees to physicians under conditions fostering the division of fees between the laboratory and the referring physician; and

WHEREAS, It is desirable to encourage scientists of professional status, such as chemists and bacteriologists with doctoral degrees, to work cooperatively with physicians for the welfare of patients and in the interest of public health; and

WHEREAS, The independent practice of laboratory medicine, generally known as pathology, by persons without medical licensure degrades the practice of medicine and of pathology in particular, is against the public interest and seriously lowers the medical and scientific standards of medical practice; and

WHEREAS, The medical profession generally has always placed the common good above self-interest and has adhered to ethical and moral principles; now therefore be it

Resolved, That the State Medical Society of Wisconsin hereby declares that the proper conduct of laboratory analyses is a medical professional responsibility and all specimens for such analysis should be referred to laboratories supervised by fully qualified and licensed physicians.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended that the resolution condemning the proposed King–Anderson legislation contained in this report be adopted by the House, and further recommended that every effort be made by the physicians of Wisconsin to enlist the support of the Legislature in the passage of the bill to implement the Kerr–Mills Act in Wisconsin in the 1963 Session.

The Reference Committee also commended the Council on its letter written to Senator Proxmire and its plans for a personal letter-writing campaign. It urged that every physician personally write letters in opposition to the King–Anderson bill and encourage their friends to do the same within the next two weeks.

The Reference Committee recommended acceptance of these portions of the supplementary report of the Council.

HOUSE OF DELEGATES ACTION—Adopted those portions of the supplementary report of the Council as recommended by the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended unanimous approval of the resolution as presented and forwarded by the Council, expressing appreciation to the American Medical Association in connection with the recent Presidents' and Secretaries' Conference.

Recommended adoption of the resolution regarding the practice of pathology and physician supervision of commercial laboratories.

Concurred in the recommendation of the Council to extend the recognition of dermatology as a specialty section.

HOUSE OF DELEGATES ACTION—Adopted these portions of the supplementary report of the Council as recommended by the Reference Committee.

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REPORT OF TREASURER—1961–1962

F. L. Weston, M. D., Madison

In accordance with Section 3, Chapter 5 of the Bylaws of our Society, I submit to you my annual report.

As in previous years I am reporting to you here only on those funds which are the direct responsihility of the Treasurer designated as the Society's "General Fund." Information on financial condition and income and expenditures of related activities of the Society is submitted to you separately, in accordance with a recommendation made to you in 1960 by the Reference Committee on Reports of Officers, which you adopted.

The following exhibits and schedules make up this report:

Exhibit A—Financial Statement at December 31, 1961
Schedule A-1—Reconciliation of Net Worth—Year Ended December 31, 1961
Exhibit B—Statement of Income and Expense—Year Ended December 31, 1961

Your Society's operations during 1961 show a reduction in Net Worth. To provide for certain expenditures the Council approved carry-overs from prior years, and approximately $9,000.00 of expenditures were charged to these appropriations rather than to current income. Net revenues from the *Wisconsin Medieal Journal* did not materialize as expected, which, for the most part, accounts for

the remaining reduction of the General Fund Surplus. This reduction of $6,406.67 is a variation of 1.8% from the budget which was adopted by the Council.

The records of the State Medical Society of Wisconsin have been audited for the year 1961 by Donald E. Gill & Company, Certified Public Accountants.

Exhibit A

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

FINANCIAL STATEMENT
December 31 ,1961

ASSETS		
Cash	$43,578.92	
Accounts Receivable	493.85	
Due From Society Divisions—Current	10,297.67	
Due From Related Organizations—Current	23,269.62	
Guaranty Deposit	425.00	
Working Capital Advance—Wisconsin Medical Journal	18,354.39	
Furniture and Equipment—Cost Less Depreciation	9,323.48	
Prepaid Expenses and Deferred Charges	11,325.26	
TOTAL ASSETS		$117,068.19
LIABILITIES		
Accounts Payable	$ 4,881.99	
Due Officers and Employees	1,829.69	
Dues—Suspense	418.00	
Accrued Payroll Taxes	14,621.39	
Prepaid Membership Dues and Assessments	2,065.00	
Other Prepaid Income	12,274.50	
TOTAL LIABILITIES		36,090.57
NET WORTH		
Surplus—General Fund	$61,661.19	
Net Worth of Wisconsin Medical Journal	18,354.39	
Surplus Reserved for Section on Medical History	962.04	
TOTAL NET WORTH		$ 80,977.62

Exhibit B

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1961

INCOME		
Membership Dues	$249,960.25	
Dues—Section on Medical History	610.00	
Annual Meeting	26,500.50	
Administrative Services	2,599.51	
Miscellaneous Income	1,129.70	
Gain on Disposal of Fixed Assets	122.02	
TOTAL INCOME		$280,921.98
EXPENSES		
Auditing and Accounting Consultation Services	$ 3,573.74	
Conference Expense	31,416.91	
Depreciation	3,055.31	
Legal Services	8,564.50	
Legislative Retainer	8,000.00	
Office Supplies	3,953.91	
Outside Services	8,243.85	
Payroll	124,149.23	
Payroll Taxes and Employee Benefits	11,530.72	
Postage and Express	11,947.35	
Printing and Forms	16,187.99	
Rent—Central Office	21,130.00	
Rent—Other	6,925.20	
Telephone and Telegraph	3,220.56	
Travel Expense—Staff	10,054.03	
Other Expenses	27,060.98	
Total	$299,014.28	
Less: Portions of Above Expenses Charged Out for Services Rendered to Others	2,931.23	
TOTAL EXPENSES		296,083.05
EXCESS -EXPENSES OVER INCOME		$(15,161.07)

NOTE: A portion of above expenses is chargeable to special appropriations of surplus at January 1, 1961, carried over to 1961 operations. Allocation of the above Excess of Expenses Over Income is as follows:

To Special Appropriations	$(9,039.40)
To Unappropriated Society Surplus	(6,406.67)
To Surplus Reserved for Section on Medical History	285.00
TOTAL	$(15,161.07)

( ) Denotes Red Figure.

Schedule A-1

State Medical Society of Wisconsin
General Fund
Madison, Wisconsin

RECONCILIATION OF NET WORTH
Year Ended December 31, 1961

	Section on Medical History	Wisconsin Medical Journal	CARRY-OVER		Unappropriated Society Surplus	Total
			Open Panel	Washington Trip		
Balance—January 1, 1961	$677.04	$17,703.42	$ 8,500.00	$ 3,000.00	$65,607.26	$95,487.72
Additions						
Working Capital Advance—Wisconsin Medical Journal		650.97				650.97
Excess—Income Over Expenses	285.00		(6,746.09)	(2,293.31)	(6,406.67)	(15,161.07)
Total	$962.04	$18,354.39	$ 1,753.91	$ 706.69	$59,200.59	$80,977.62
Transfers						
Balances Closed to Unappropriated Current Surplus			(1,753.91)	(706.69)	2,460.60	
Balance—December 31, 1961	$962.04	$18,354.39	$	$	$61,661.19	$80,977.62

( ) Denotes Red Figure.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the report as submitted and thanked Doctor Weston for his continued efforts on behalf of the Society.

The Committee thanked the staff and the certified public accountants retained by the Council for their tabulation showing financial condition and income and expenditures of the

Society and its related activities. Commented that the report was informative and requested that this type of report be provided delegates on a continuing basis.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer as recommended by the Reference Committee.

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REPORT OF SECRETARY—1961–1962

Mr. C. H. Crownhart, Madison

An annual comment of the Secretary is to say something to the effect that the report of the office is reflected in the reports of the various committees and commissions; and in a real sense that is true, for it is under their direction that the implementation of decisions takes place at the administrative level.

There are some matters to highlight and my comments on a few of them follow.

Corporate Structure of the Society and Staff Organization

Figure 1 presents the corporate structure of the Society and its affiliates. Those boxes with waved edges are to emphasize points of authority. The staff organization (Fig. 2) is held only to principal administrative positions. You will note that in the case of the Controller, Personnel Director, and Office Services Director . . . each reports to the Secretary as well as to the Insurance Director.

"Gas pipe plumbing" has its values, of course, and always is a delight of office management. It has its liabilities as well, and not the least of these is the tendency to demolish team play, a vital element in the development of a well rounded service organization.

However, in judging of administrative responsibilities and activities, the House may well find both these charts of value.

(See charts on following pages.)

Further Comments on Special Report of Secretary and Legal Counsel

Since legal counsel and the Secretary filed the special report requested of them by the House of Delegates in 1961, a number of comments and further suggestions have been made, often during the caucus of delegates in various areas of the state.

One of these is that our suggestion as to length of term of office of the councilor involves too long a time. We amplify our report here to point out that these are only suggestions, and if the proposed amendments are formally introduced, they will lie over until 1963 in any event. They are subject to any action the House may care to take at that time, including amendment.

Another suggestion is made that the President and the Speaker of the House be given voting privileges in Council sessions. The Council by tradition has been considered the senate of the Society, with the House being its assembly. . . and by tradition, there has also been a separation of the Presidential office from the legislative branch.

However, it is quite possible to provide these two officials with voting rights in meetings of the Council, and should that now be considered advisable, it could be accomplished by the following amendment to Article VI of the Constitution.

RESOLUTION "E"

Resolved, That Article VI of the Constitution be amended to read as follows:

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The (president, the) president-elect, the secretary, *and* the treasurer (and the speaker of the House of Delegates) shall be ex officio members of the Council, but without the right to vote, *and the president and speaker of the House of Delegates shall be ex officio members with such right to vote.* (Nine) *A majority* of its *voting* members shall constitute a quorum.

Material to be deleted is shown in parentheses; new material is in italic.

Since such an amendment would increase the voting membership of the Council to 23, it would seem that the quorum should then be changed to a majority of voting members.

Responsibilities in the National Scene

We have all observed during the past several years that activities in Washington by Congress and administrative agencies have effectively centralized the determination of much of the legislative policy of our country.

When I first came to the Society on a full-time basis, the major interest by far was on the home front. And it stayed that way for a long time. Our bulletins were long and frequent. Washington, on the contrary, commanded but little of a state society's time or staff.

But now it is clear that Wisconsin must "go Washington" as must other state organizations if effective medical leadership is to be provided in the area of health legislation. And Wisconsin is doing just that.

Its Committee on Health Economics of American life (HEAL) has been so organized as to represent every congressional area of the state. Its activities have been pronounced and effective. As one example, its chairman, Doctor Allin, and the Society's legal counsel appeared in opposition to Bill H. R. 4222, to provide health services for the aged under the Social Security system, in July of 1961.

And Doctor Allin, along with Doctor Starr of Viroqua, will attend the 22nd Wisconsin Congressional Dinner in Washington on May 1, 1962. At the time this report is written, the entire Wisconsin delegation to Congress will be present, along with such other prominent Wisconsinites as Undersecretary of Health, Education and Welfare, Ivan Nestingen; Assistant Secretary of Defense (manpower) Carlisle P. Runge; Commissioner of Indian Affairs, Phileo Nash; and Judge of the U. S. Court of Claims, James R. Durfee.

Last year a representative committee of Wisconsin physicians engaged in a well-planned series of interviews with Washington officials, and activity by our Society is being shaped now as a result of this type of planning.

In Wisconsin, the state society is the distributing medium for much material relating to medical-socio-economic matters. Cooperation with the AMA is freely extended in all respects, and its requests of the Society staff are considered of priority status.

CORPORATE STRUCTURE OF THE STATE MEDICAL SOCIETY OF WISCONSIN AND ITS AFFILIATES

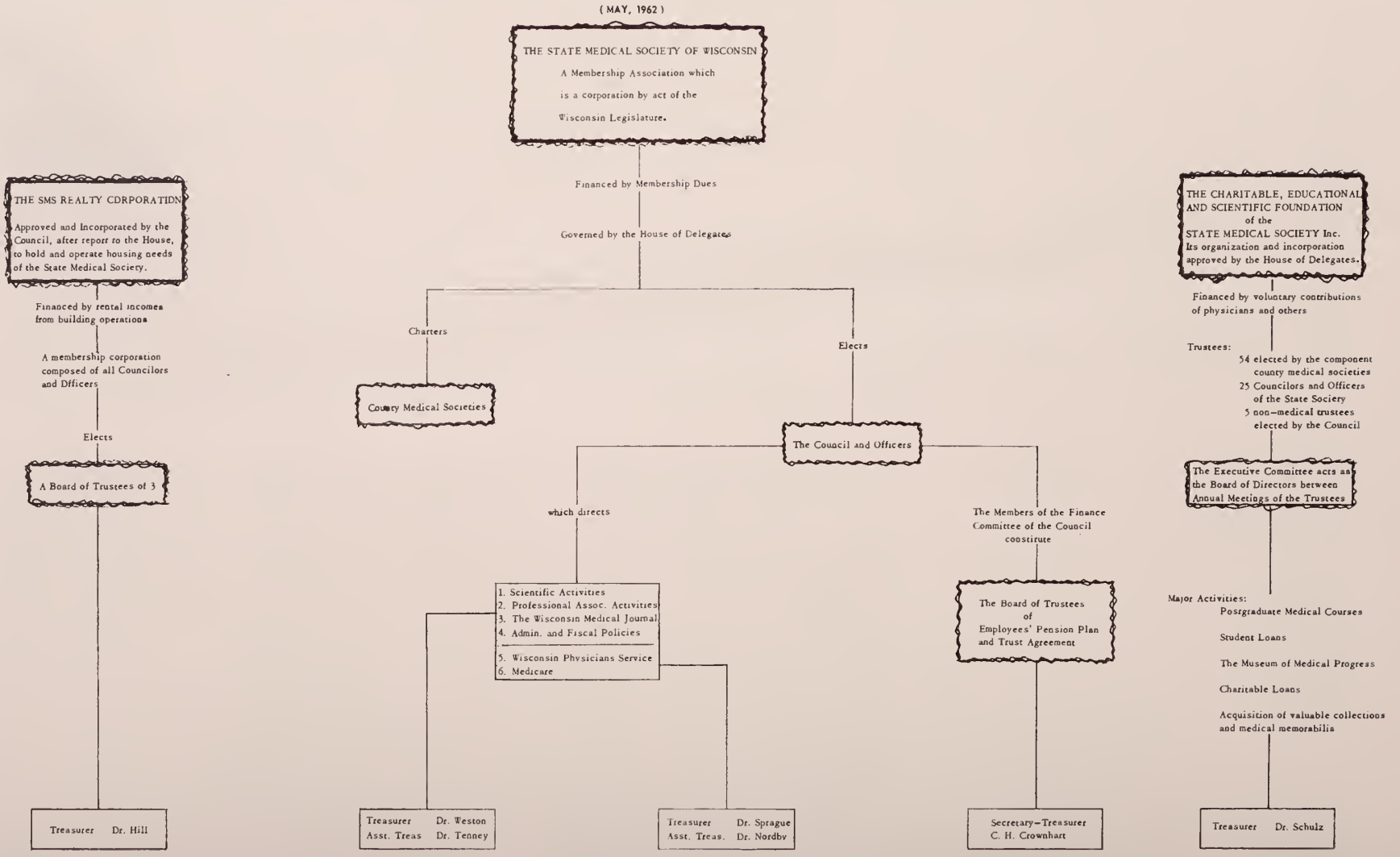


Figure 1

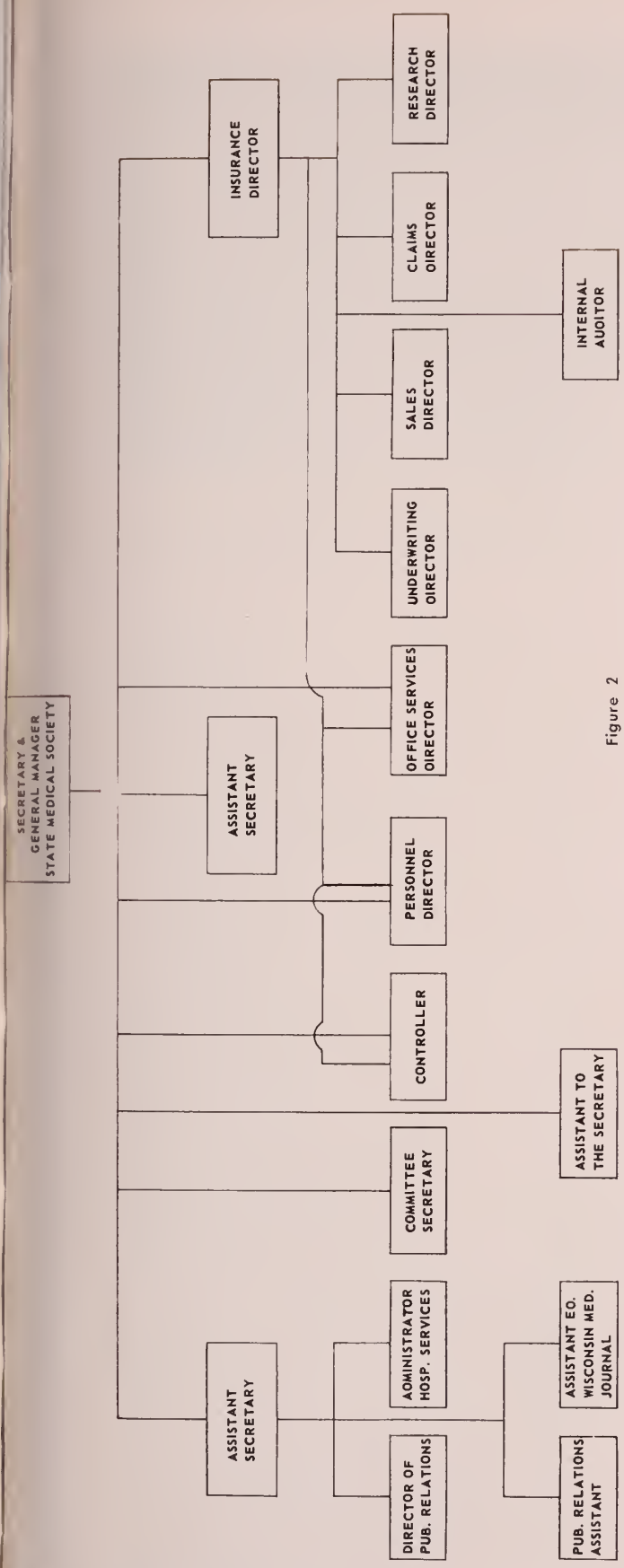


Figure 2

Fiscal Notes to Recommendations of New Projects

Each year sees new projects initiated as a result of reports of officers, committees and others. This is as it should be. The Secretary feels that it should be an accepted procedure, however, to require a fiscal note as to what costs are involved, including staffing and other implementation. Such a ruling by the House of Delegates would, I think, have more than one salutary effect.

Planning by the recommending body as to costs would cause careful evaluation, not only of the project itself, but of the extent to which the project should be carried out. Still another would be the effect on the staff concerned, to the point that they would be required to consider this aspect as they meet with various Society committees and officers.

In my service with the Society I have never experienced the "deaf ear" when I have raised financial and staffing problems. But the caution should be more than an administrative one and an official statement by the House seems will in order.

The Impact of Time

Physicians hardly need to be reminded that their chief stock in trade consists of their skills and their opportunity to apply them. However you measure it, the principal factor is one of reasonably available time.

That's a problem in staffing a medical society too.

A decision is reached, for example, to press for Wisconsin legislation authorizing personal service corporations. The general purpose and ultimate effect can be simply stated. But not so in the law itself. Here there must be skilled drafting and the handling of a multitude of details in arriving at implementing decisions. For example, the traditional corporation consists of at least three stockholders. In a personal service corporation of physicians, stockholders should obviously be physicians, otherwise lay (I prefer the term "non-medical") control of the practice of medicine could result. But studies indicate that the majority of physicians are solo practitioners or are in partnerships or other association with but one other physician.

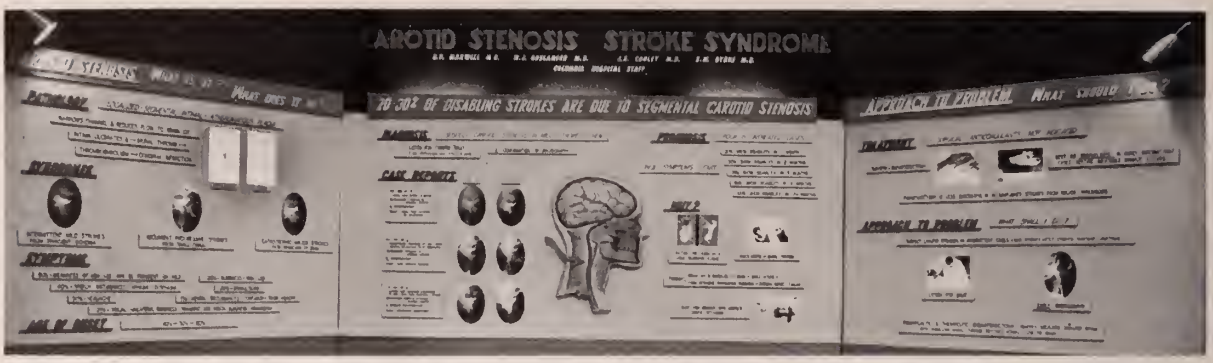
In light of these facts, which had to be ascertained, the project was expanded to provide the broadest opportunity possible for all practitioners under this law.

Implementing Kerr-Mills in Wisconsin, an effort which failed this year, presented more than one difficulty in preparing the legislation. The State Medical Society felt that since the law is aimed most directly at health care problems of the aged, there should be physician participation in policy development. But the Kerr-Mills law calls for administration by Welfare agencies. The solution: provide that the State Board of Health be an official advisory body to Welfare authorities.

These are illustrative of legislative matters in which time is so measurable as to be unappreciated except by those intimately close to the problem.

In yet another area, take a look at the responsibilities of the Committee on Military Medical Service. Its report to the House is but two pages long, and while adequate enough in itself, does not tell the story behind the scenes. The committee properly decided that to secure advice on availability or essentiality, there must be an adequate inventory of physicians based upon *their* military commitments. Questionnaires to this point were circulated and all but a minute fraction were returned. These answers went through the IBM machinery to locate physicians by military status, if any, and by county, type of practice, and other considerations. This was impact of time necessary to implement the survey.

Even this could not be accomplished in time to avoid all problems. In one location, a physician was



CAROTID STENOSIS—STROKE SYNDROME, Drs. Harry P. Moxwell, Woyne J. Boulonger, Jomes E. Conley, ond Robert W. Byrne, Columbia Hospitol, Milwoukee. Coses were presented to illustrate the clinicol feotures of the vorious stroke syndromes coused by carotid stenosis. Illustrotions included pre- and post-operative angiogroms, operative procedures, and gross ond microscopic pothology.—Second ploce winner Lorger Hospitols ond Universities class, scientific exhibits.

called on active duty, while a Selective Service board in another state seemed inclined to feel that the same Wisconsin community could part with still another practitioner registered in his state of earlier residence, not Wisconsin. Many situations before that committee seemed to justify the comment in one letter to the effect that its members were "damned if they did and damned if they didn't."

I won't belabor the point. I just hope I have made it clear. And its what I try to explain to those few physicians who have made the comment to me that the dues are too high, or as one put it: "What do *you* do with all that money?"

What is needed, ordinarily, is opportunity for the staff to re-tool for new operations. We have that opportunity as to programs which repeat themselves periodically but are not continuous. Take the Open Panel under the Workmen's Compensation law. Here, every three years, we set up the project of listing all physicians desiring to be available to treat compensable injuries. We must verify his correct address and telephone number. We ultimately address these panels to about 90,000 places of employment in the state, and by the time we are through with the project, have expended about $1.00 per member per year, plus the staff time and indirect costs involved. And from tests made, we are satisfied that about 90% of places of employment in Wisconsin subject to the compensation law do post our panel and keep it current.

The fiscal note approach should help timing of these matters in the future, and the ability of the staff to get itself into gear to implement the various decisions made through Society mechanisms.

This report, on re-reading, makes me realize that I've written in a philosophical approach as well as telling you facts. The work of the Society is responsible and effective. To be working with it is a gratifying experience. The staff feels itself a part of your program, and that is as it should be. Thank you for the fine year of cooperation just being completed.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the Secretary's report. The Committee gratefully acknowledged the fulfillment of the request of the House in 1961 that a breakdown of the corporate structure of the State Medical Society be presented.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary as recommended by the Reference Committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended introduction and acceptance of Resolution E from the report of the Secretary.

Recommended that the dues of the Society remain the same for 1963. The Committee reminded members that an increase of $10 in AMA dues was scheduled for 1963.

Concurred in the recommendations of the Secretary as to Fiscal Notes to Recommendations of New Projects and recommended their acceptance.

HOUSE OF DELEGATES ACTION—Adopted Resolution E from the Secretary's report as introduced and recommended by the Reference Committee. (Proposed constitutional amendment must be laid over one year for final vote.)

Adopted the recommendation of the Reference Committee that the Society dues remain the same for 1963.

Adopted the Reference Committee recommendation that the Fiscal Notes to Recommendations of New Projects be accepted.

ADDITIONAL REMARKS BY THE SECRETARY

It is my duty to inform you as to Article IX, Section 2 of the Constitution, which provides:

> The officers, except the Councilors, shall be elected annually. The terms of the Councilors shall be for three years. There shall be elected one Councilor for each of the thirteen districts, except that in any Councilor District embracing a membership of 250 or more there shall be elected one additional Councilor for each additional 250 members or major fraction thereof.

It is my duty to certify to the House, as I did in 1956, that the records of my office indicate the total membership in the Third Councilor District, as of December 31, to have reached 637 members, consisting of 506 in the Regular classification, 53 Residents, 14 Associates, 11 Affiliates, 9 Life, 2 Military, 3 Honorary, 7 Educational, 13 Age-exempt, and 9 Career Appointments.

It is my duty to also certify to the House, as I did in 1956, that the records of my office indicate the total membership in the Sixth Councilor District, as of December 31, to have reached 381 members, consisting of 342 in the Regular classification, 7 Residents, 3 Associates, 2 Affiliates, 11 Life, 2 Military, and 14 Age-exempt.

I can therefore certify to the House that the Third and Sixth Councilor Districts are entitled to one additional member on the Council.

HOUSE OF DELEGATES—Certified eligibility of Third and Sixth Districts for additional councilors.

BLOCK THAT NERVE, Drs. Morvin Wagner and Sheldon Burchman, Department of Surgery, Mt. Sinai Hospitol, Milwoukee. The exhibit demonstroted onotomicol diagrams of bicipital sulcus regional blocks for anesthesio far injuries of the upper extremity. Also shown were demonstrotians of the hazards with the brachial plexus block in the supraclavicular orea, and the "blind black" with the oxillary approach.—Hanarable mentian, Smaller Hospitals and Individuols class, scientific exhibits.

SUPPLEMENTARY REPORT OF SECRETARY 1961–1962

Necralagy Report

The Council reports with sorrow the deaths of the following physicians since the last Annual Meeting. Members of the Society are indicated in italic.

R. K. Irvine, M. D., Manawa
A. Kovacs, M. D., Milwaukee
E. R. Schmidt, M. D., Madison
T. R. Murphy, M. D., Milwaukee
R. P. Welbourne, M. D., Watertown
J. P. Kochler, M. D., West Bend
A. E. Coletti, M. D., Madison
J. P. Rowan, M. D., Milwaukee
J. S. Stefanez, M. D., Milwaukee
E. C. Pfeifer, M. D., Racine
F. T. Weber, M. D., Arcadia
F. B. Marek, M. D., Racine
A. V. De Neveu, M. D., Wyocena
W. B. Cornwall, M. D., Amery
E. O. Gertenbach, M. D., Milwaukee
L. E. Coffin, M. D., Tucson, Ariz.
M. B. Byrnes, M. D., Milwaukee
J. E. Newton, M. D., Hudson
J. A. Heraty, M. D., Milwaukee
W. A. Schweitzer, M. D., Milwaukee
E. L. Bolton, M. D., Appleton
I. I. Cowan, M. D., Milwaukee
R. J. Depner, M. D., Milwaukee
C. C. Differt, M. D., Sheboygan
E. A. Schmidt, M. D., Elm Grove
B. E. Reynolds, M. D., Avoca
E. D. Schwade, M. D., Milwaukee
P. G. Frey, M. D., Milwaukee
E. S. Elliott, M. D., Fox Lake
R. R. Rivard, M. D., Shawano
F. J. Gosin, M. D., Long Beach, Cal.
B. A. Hoermann, M. D., Milwaukee
R. J. Hudson, M. D., Sauk City
F. Raine, M. D., Milwaukee
E. E. Gallagher, M. D., La Crosse
C. R. Marquardt, M. D., Milwaukee
L. V. McNamara, M. D., Milwaukee
J. B. Schrock, M. D., Sharon
H. C. Alley, M. D., Eleva
P. E. Wright, M. D., De Pere
F. H. LeWohl, M. D., Racine
J. W. Fons, M. D., Milwaukee
N. F. Crowe, M. D., Delavan
C. C. Skinsness, M. D., Viroqua
W. Cunningham, M. D., Platteville
G. Hoffman, M. D., Manitowoc
H. F. Derge, M. D., Eau Claire
A. D. Beutler, M. D., Milwaukee
A. C. Radloff, M. D., Plymouth
R. L. Cowles, M. D., Green Bay
M. Grossman, M. D., Green Bay
L. E. Vaughn, M. D., Beloit
S. G. Schwarz, M. D., Merrillan
W. H. Dushack, M. D., Sun Prairie
H. M. Coon, M. D., Wauwatosa
J. F. Dunn, M. D., Whitewater
Else Knudsen, M. D., Iola
R. H. Wiley, M. D., Iola
J. R. Venning, M. D., Ft. Atkinson
W. L. Johnson, M. D., Janesville
F. D. Weeks, M. D., Ashland
I. H. Hartman, M. D., Madison
H. J. Haubrick, M. D., Oshkosh
C. J. Maercklein, M. D., Redgranite
C. Malone, Jr., M. D., Madison
G. S. King, M. D., Hudson
J. S. Tenney, M. D., Alma
H. A. Hoyer, M. D., Milwaukee
H. N. Winn, M. D., Madison
V. L. Satterlund, M. D., Star Prairie

Membership Report

For the year ending December 31, 1961

Members paying no dues		164
Affiliate members	47	
Military service members	29	
Honorary members	7	
Life members	60	
Special service members	4	
Transfer members	17	
Total	164	
Members paying prorata dues (military service returned and new after July 1)		53
Associate members		53
Members in residency training		166
Members paying full dues		3162
Educational members		8
Total		3441
Total membership		3605

State Medical Society of Wisconsin

TOTAL MEMBERSHIP BY COUNTY

DECEMBER 31, 1961

County Society	Regular	Resident	Associate	Affiliate	Life	Military	Honorary	Educational	Special Service	Career app't.	Total
Ashland–Bayfield Iron	17		1	1	1						20
Barron–Washburn–Sawyer–Burnett	33	3		1							37
Brown	108	4	1	1							114
Calumet	7										7
Chippewa	24										24
Clark	14	2									16
Columbia–Marquette–Adams	30		2								32
Crawford	8										8
Dane	340	49	8	6	2	11	3	7		9	435
Dodge	42	1		1							44
Door–Kewaunee	19	1									20
Douglas	24					1					25
Eau Claire–Dunn–Pepin	72	1	2	1	4						80
Fond du Lac	62	1			3	2					68
Forest	4			1							5
Grant	29		1		1						31
Green	33	1		1	1						36
Green Lake–Waushara	13	1			1						15
Iowa	12				1						13
Jefferson	35	3	1	1	1						41
Juneau	5										5
Kenosha	64		4	1					1	1	71
La Crosse	89			5							94
Lafayette	8			2							10
Langlade	13										13
Lincoln	14		1		2						17
Manitowoc	46				1						47
Marathon	62	1		1	1						65
Marinette–Florence	15	1	1								17
Milwaukee	1079	77	17	13	15	8	3	1	3	8	1224
Monroe	14				1						15
Oconto	8	1				1					10
Oneida–Vilas	23	1		1							25
Outagamie	82	1	1		2						86
Ozaukee	17										17
Pierce–St. Croix	29	1			2	1				1	34
Polk	22	2									24
Portage	25										25
Price–Taylor	8					1					9
Racine	109	4		4	3	1	1				122
Richland	12		1								13
Rock	96	2	4	2	6	1					111
Rusk	5										5
Sauk	20	1		2							23
Shawano	14										14
Sheboygan	67	1	3		3						74
Trempealeau–Jackson–Buffalo	22	1	1								24
Vernon	16										16
Walworth	27					1					28
Washington	26	1			1						28
Waukesha	88	2	2	1	1	1					95
Waupaca	19	1									20
Winnebago	79		1	1	6						87
Wood	64	1			1						66
Totals	3213	166	52	47	60	29	7	8	4	19	3605

ADDITIONAL REMARKS OF THE SECRETARY

In addition to the deaths which have been reported in the Supplementary Report above, the office records the deaths of the following physicians:

C. B. Hake, M. D., Milwaukee
Seth R. Medley, M. D., Spooner
Edward T. Lautenbach, M. D., Brandon
Matthew W. Biljan, M. D., West Allis
H. P. Landry, M. D., Cadott
J. W. Truitt, M. D., Fort Lauderdale, Florida
David F. Cole, M. D., Ripon

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the Secretary's supplementary report.

HOUSE OF DELEGATES ACTION—Adopted the Secretary's supplementary report as recommended by the Reference Committee.

SPECIAL REPORT TO THE HOUSE OF DELEGATES BY SECRETARY AND LEGAL COUNSEL —MAY 1962

C. H. Crownhart, Secretary

R. B. Murphy, Counsel

Instructions of the House in 1961, contained in the report of the Reference Committee on Resolutions, directed the staff and legal counsel to draft suggested changes in the Bylaws which would:

(1) Limit tenure of office and committee membership and commission membership to three consecutive terms.

(2) Designate major State Medical Society committees, divisions, or councils (major committees); and

(3) Eliminate "multiplicity of portfolio occupation" as designated in such committees; and to present such draft recommendations to the next

meeting of the House of Delegates for its consideration.

A. Length and number of councilor terms

Since Article IX, Sections 1 and 2, of the Constitution prescribe the method of nomination of councilors and a term of three years, it follows that the Constitution must be amended to limit their terms. Bylaws are subordinate to the Constitution and cannot modify or limit constitutional provisions unless the Constitution expressly so permits.

We emphasize that at some earlier point in the deliberations of the State Medical Society, the state was divided into 13 councilor districts; and that at such time there was no provision to permit a district to have more than one councilor. Neither was there any limitation upon how a councilor should be nominated for office. Provisions for additional councilors and method of nomination all followed upon the original constitutional provision.

With the amendment providing for more councilors based upon physician population, four have been added from the 12th District; one has been added from the Third District; and at the 1962 session of the House an additional councilor each is entitled to be seated from the Third and Sixth Districts. This brings the total number of councilors, then, to twenty, and with the immediate past president as a voting member, the Council will then consist of twenty-one voting members.

Officers of the Society, other than the voting members of the Council, include the president, president-elect, treasurer, secretary, speaker and vice speaker. Invited to Council meetings are the four AMA delegates and their alternates. We emphasize, as we have on prior occasions, that this leads to a sizable meeting with less opportunity for full deliberation than in earlier years.

Furthermore, under the present three-year term for voting members of the Council, exclusive of the immediate past president, it is conceivable that within two years the Council could be changed as to its voting complexion, experience, and background.

We feel that this is impractical and dangerous to the very stability of an organization which is guided by principles of long duration, and to an organization which is financially responsible for the proper handling of millions of dollars annually.

To impose upon the councilor district any limitation upon the term of a councilor which is, as a practical matter, unrealistic, is to impose upon that same district a dictatorial mandate diametrically opposed to the democratic organization of the State Medical Society. So long as nominations can be made only from within the district, then the district should be assured of the greatest freedom of choice possible in exercising this prerogative.

We therefore recommend that:

(1) The terms of councilors be extended from three to five years

(2) A councilor be limited to three consecutive full terms; and

(3) An intervening term of office or a partial term served by election or appointment to fill a vacancy be excluded from the three term limitation.

Resolution "A" to accomplish this recommendation is attached as part of this Report, but we point out that it must be formally offered to the House of Delegates by a delegate or delegates. Being a constitutional amendment, it could be introduced at this session of the House and, under the terms of the Constitution, then be laid over until 1963 when it may be finally acted upon.

B. Terms of delegates to the State Medical Society

Our recommendations do not include any limitation upon terms of those elected to this House. Since the choice is that of the component county societies or of sections, it is within the power of each to prescribe any such limitation in its own constitution and bylaws.

C. Terms of speaker and vice speaker

Officers of the Society include the speaker and vice speaker. It is in the parliamentary tradition of most democratic bodies, organized as is this House, to continue its presiding officers in office, and to assist the orderly processes of debate and action through retaining leaders of experience. We believe that a longer term in office would make the speaker better acquainted with the structure of the Society, with membership of the House, facilitate his appointment of the membership of reference committees, and in many other ways enable him to play the important role which the office calls for in the functioning of the Society.

We recommend to the House serious consideration of appropriate amendments to provide that the term of office of the speaker and vice speaker shall be two years, and that they be elected in alternate years. Resolution "B" would accomplish this result.

D. Multiplicity of offices

When it comes to the matter of "multiplicity of portfolio occupation," we first emphasize strongly that the Council *is* the Board of Trustees or Board of Directors, however one may wish to term it, of a large, complex, functioning organization. The Constitution even grants the Council the powers of the House between sessions. The Council, in its long years of experience, has seldom exercised such emergency powers; but in our experience with it, has faithfully and responsively discharged its duties as a group of trustees. At times it has taken total charge of projects within its own structure. It has committees within its own structure appointed representatively of its membership, and in such manner as to enable them to screen recommendations, problems and policies under Council consideration.

The Council has been charged by this House of Delegates, and very properly so, with direct responsibility for management of the Society's policies in prepaid health insurance. It has been charged by this Society, and again properly so, with the establishment of effective liaison with the many departments of the state government in Wisconsin. It is responsible in the final analysis for the financial operations of the Society.

The job of an individual councilor is a demanding one. He is involved in four regular meetings of the Council each year and sometimes in special ones. As a councilor he is a member of one of its standing committees. The Executive Committee of the Council, composed of the chairmen of other standing committees, meets monthly. The Finance Committee may meet three to five times a year. The Planning Committee has an onerous task, as do the Committees on Economic Medicine and Scientific Medicine.

A councilor is involved in the Society's annual meeting for a total of approximately six days. A councilor, to be effective, attends meetings of the county medical societies in his district. If members generally of the State Medical Society are prone to comment upon the mailings they receive in the interest of the organization, then perhaps they will be appreciative of the material supplied each councilor almost weekly. The agenda and support-

ing material for the annual meetings of the Council may run between 50 and 100 pages of mimeographed material.

The House of Delegates in electing the individual councilors votes its confidence in them as being worthy of the task. To direct the Council to limit terms of members of committees it appoints or of committees it selects within its own membership would be wholly incompatible with the charge of duty upon them. These men not only have ethical and moral responsibilities in their position, but must measure to the stern test of law in such matters as conflict of interest, judicious management, and a host of other responsibilities.

We cannot recommend any amendment to the Constitution or Bylaws which would *limit councilors in the use of their judgment of how to discharge their duties;* and we do not think that the House of Delegates, in considered judgment upon this matter, would wish us to do so.

However, it is entirely proper to provide that members of the Society shall not hold more than one office as those are listed in the Constitution. Resolution "C" attached would accomplish this purpose.

E. Major committee structure

In Chapter VII of the Bylaws, six appointed committees of the Society are enumerated. No one of them can be selected as more important than the others. Each of these committees is concerned with long-range policy. Weariness and a sense of satisfaction in having served his fellow physicians seem to be satisfactory components to provide a predictable turnover and infusion of new blood. Each incoming president of the State Medical Society desires, and properly so, to recognize those of his friends within the profession whom he as an individual has learned to respect and to feel they will faithfully discharge the responsibilities involved in appointment to one of these standing committees. Should the House, however, wish to limit terms of such appointees, it can provide a total limitation of not to exceed three consecutive terms. Resolution "D" to accomplish this purpose is attached as a portion of our Report.

F. Delegates to the American Medical Association

We do not consider that Wisconsin's delegation to the AMA was to be included in our Report. By the very nature of things, these representatives must not only be knowledgeable in the affairs of the Society, but we can assure members of this House that experience in the AMA does not come about easily. There are, at present, two meetings annually involving about ten days of total time, perhaps more. Leadership in affairs of the AMA has often been asserted by Wisconsin delegates in the past, but to be effective a delegate must do his "home work" of becoming known, engaging in correspondence, and a host of other contacts. At least one state constitutes its Council as the nominating committee for careful choice of those available. We believe that in another state choice is by Council appointment. In any event, we do not feel called upon to suggest a form of resolution as to these positions since they are not officers or committee members as such.

Finally, we point out that at the time of preparation of this report a special assessment has been levied for the purpose of a management survey of the State Medical Society, each of its component medical societies, and the two Blue Shield plans in Wisconsin. We recommend that this report be laid over to permit its consideration in the survey itself.

RESOLUTION "A"

Resolved, That Section 2 of Article IX of the Constitution be amended to read as follows:

"The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for *five* years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

"As nearly as possible, one *fifth* of the members of the Council shall be elected each year. *No councilor may serve more than three consecutive full terms, exclusive of partial terms served to fill a vacancy; provided such limitation shall not apply to terms which are being served at the time this amendment becomes effective.* The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

"The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect."

(New matter in italic.)

RESOLUTION "B"

Resolved, That the first paragraph of Section 2 of Article IX of the Constitution be amended to read as follows:

"The officers, except the councilors, *the speaker and vice speaker of the House of Delegates,* shall be elected annually. *The terms of the speaker and vice speaker shall be for two years each, the election of each to be held in alternate years commencing with the term of the speaker elected in the year in which this amendment takes effect.* The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof."

(New matter in italic.)

RESOLUTION "C"

Resolved, That Section 1 of Article IX of the Constitution be amended by the addition of the following paragraph:

"No person shall hold more than one of such offices concurrently."

RESOLUTION "D"

Resolved, That the second paragraph of Section 1, Chapter VII, of the Bylaws be amended to read as follows:

"Unless otherwise *expressly* provided in these Bylaws, each of these committees shall consist of five members, each of whom shall serve for a term of five years, *and no person shall serve on any one of the above committees more than three consecutive terms.* One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, three, four, and five years, and thereafter for terms of five years each."

(New matter in italic.)

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS. Drs. E. P. Rohde, Galesville; C. J. Strong, Borron; R. G. Zoch, Monroe; and Edgor End, Wouwotosa, choirman. Dr. C. J. Picord, Superior, olso was o member of the committee.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recommended that Resolution "A" be not introduced because it would preempt the democratic rights of local Councilor Districts.

In the spirit of the resolution submitted by the Reference Committee on Resolutions in 1961, the Committee recommended to each councilor district that no councilor be elected to more than three consecutive terms, and that this recommendation be brought to the attention of the councilor districts prior to such elections. The Committee recommended the acceptance of this portion of the report.

Recommended that Resolution "B" of the special report be introduced in the following revised form:

> "Resolved, That the first paragraph of Section 2, Article IX, of the Constitution be amended to read as follows:
>
> 'The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more there shall be elected one additional councilor for each additional 250 members or major fraction thereof.' "

Recommended acceptance of Resolution "C" of the special report without change.

Recommended that Resolution "D" be introduced in the following revised form:

> "Resolved, That the second paragraph of Section 1, Chapter VII of the Bylaws be amended to read as follows:
>
> 'Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commisions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.' "

HOUSE OF DELEGATES ACTION—Adopted the recommendation of the Reference Committee relative to Resolution "A"; adopted Resolution "B" as revised by the Committee; adopted Resolution "C"; and adopted Resolution "D" as revised by the Committee. (Resolutions "B" and "C", being constitutional amendments, must lay over for one year before a final vote is taken of the House.)

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REPORT OF THE PRESIDENT OF THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION—1961–1962

W. D. Stovall, M. D., Madison

It is always a delight for me to meet with the State Society of Wisconsin, and it has been for many years; but tonight it is especially so because I have some very important and exhilarating announcements to make to you.

In the first place, the annual report will be found in the delegates' handbook. (A limited number of copies is available on request.) What I want to say to you particularly is the result of a trip which we made this morning.

Doctor Simenstad took his nice big plane and flew Mr. Murphy and myself down to Indianapolis, Indiana, where we had an interview with Mr. Meese, who represents the Eli Lilly company. You know through the Bulletin that the Eli Lilly company had employed Mr. Aaron Bohrod, of the University of Wisconsin, the visiting artist there, to portray for the front of their Bulletin, in a series of paintings, the advances in medical science and the methods of practicing medical science today as compared with earlier periods.

Mr. Bohrod is a distinguished artist. He has an acute sense of portraying the advances of civilization and culture of our nation. These are important paintings, and we felt most anxious to have them in Wisconsin. We wanted them for the Foundation because we wanted those paintings to portray to the public as they come to our exhibits at Prairie du Chien, and our advance in Prairie du Chien is moving along very well. We wanted to be able to offer these paintings to people in the State of Wisconsin who would like to put them on display on whatever occasion they might have that would be appropriate.

We would like to offer them to the State Historical Society for their use, for whatever means they have. The whole purpose of the thing was to promote those things that the Foundation stands for, and that is the presentation of medicine in its proper image to the public; and there is no better way to do it.

CES FOUNDATION OFFICERS: Drs. A. J. McCarey, Green Bay, vice-president; Elizabeth Camstock, Arcadia, hanarary vice-president; W. D. Stavall, Madison, president; and Gordan Schulz, Unian Grave, treasurer. Mr. Earl Thayer, Madisan, SMS assistant secretary (secand fram right), sat in for Mr. C. H. Crawnhart, Faundatian secretary.

The exhilarating part is that Mr. Meese said that through due process, which has some legal involvements that have to be worked out, the Foundation in Wisconsin will receive these paintings. We really felt this was a very important trip to Indianapolis, an important one to us.

When these paintings are delivered to us, probably some time this summer or fall, as the exact time cannot be set because they are in use at the present time, I hope the Medical Society, the President and Councilors and Secretary, will see that we have a nice reception for the officials of Eli Lilly and Company when we receive the paintings that they are giving to us.

So, this to me is quite an exhilarating thing, and it is an important thing to us in the advancement of our Museum and in the advancement of our Foundation.

The next thing I have to say to you concerns your own support of the Foundation. The activities of the Foundation will be found in your handbook. There are many: support of needy medical schools; the support of physicians who through misfortune of one sort or another need aid; the support of our Foundation by which we portray medicine to the public of Wisconsin and to the public of the nation as they pass by in their automobiles or when they make trips up the Mississippi River or wherever they may be going.

So, you will be billed eventually for a contribution to the Foundation, but there will be no stated figure as to how much you should contribute.

This, gentlemen, is an invitation to you, not for a specific set contribution to the Foundation, but for you to be liberal and generous and thoughtful and kind and helpful in portraying the thing that you are most anxious should be portrayed to the people who see these exhibits. So, we will leave it to you, but we urgently request that you be liberal in your contribution to the Foundation.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Recammended acceptance af the repart af the Charitable, Educatianal and Scientific Faundatian and expressed pleasure at the praspects af the Faundatian's receipt af the Bahrad paintings.

HOUSE OF DELEGATES ACTION—Accepted the repart af the Foundatian as recammended by the Reference Cammittee.

HONORED GUESTS

Haddon Carryer, M. D., Rochester, Minn., president of the Minnesota State Medical Association.

Clarence I. Owen, M. D., Detroit, Mich., president-elect of the Michigan State Medical Society.

Mrs. E. M. Dessloch, Prairie du Chien, Wis., president-elect of the Woman's Auxiliary to the State Medical Society.

●

REMARKS OF THE PRESIDENT OF THE WOMAN'S AUXILIARY TO THE STATE MEDICAL SOCIETY—1961–1962

Mrs. J. Haward Jahnsan, Milwaukee

I am pleased to report briefly on the work of the Woman's Auxiliary to the State Medical Society of Wisconsin for this past year.

Justice Oliver Wendell Holmes has said, "It is required of a man that he should take part in the actions and passions of his times, at the peril of being judged not to have lived."

The Auxiliary has become increasingly aware that we, as doctors' wives, must express our beliefs in the urgency of preserving our freedoms, lest we be judged not to have lived.

"Speak Your Beliefs in Deeds" has been our National Auxiliary theme for this past year. This thought has permeated our work in the fields of Legislation, American Medical Education Foundation, Health Careers and Recruitment, Scholarship, Community Service, Mental Health, Safety, Civil Defense and Child Health, to name a few.

The major project for the past year has been legislation. We as doctors' wives must be well informed as to the dangers of the current legislation. Special emphasis was placed on the value of personal letters to our elected representatives.

We believe that the Health Careers Clubs, sponsored by the Auxiliary, are of tremendous influence in the lives of our high school students in orienting them and directing their future education toward a career related to medicine. Over $4,500 has been raised by our thirty-four Auxiliaries for nursing scholarships.

Our medical schools have benefited through the Auxiliary's contribution to the American Medical Education Foundation. $5,920.23 has been donated through the dedicated work of our members.

A pilgrimage to the Museum of Medical Progress in Prairie du Chien was held in September, and many of our women are better informed about the fascinating subject of medical history in Wisconsin.

Probably our greatest area of service in the Auxiliary is that of community service in our home areas. The program varies depending on the needs of the individual community, but the doctor's wife

is constantly urged to take the lead in implementing the ideas for better community health as directed by our county and State medical societies.

I must add that our work is only half as effective as it should be, as only half of the doctors' wives in Wisconsin are members of our organization. It is easy for a doctor to realize the importance of his being a member of the American Medical Association. It is most important, too, that the doctor's wife be a part of the Medical Auxiliary program.

I have learned to know the doctors' wives throughout the State much better this past year. Without a doubt they are the most charming, hard-working and capable group of women I have ever been associated with.

I want to express my deep appreciation to two individuals: First, to my husband, who has been so helpful, patient and wonderful about the demands of this office. I could not have accepted this position without his encouragement.

The other person I am deeply indebted to is Leona Chesemore. I would like to express my sincere appreciation to the State Medical Society for providing such an outstanding person as Mrs. Chesemore to work with us. She is so very capable in countless areas, and through her know-how it is possible to maintain a valuable continuity of program from one year to the next.

In closing, I cordially invite you to visit the Art Show on the stage of the Auditorium where oils and watercolors, painted by Wisconsin doctors and their wives, are on exhibit. Coffee will be served by Auxiliary hostesses.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the report of the Woman's Auxiliary to the State Medical Society. The Committee commended Mrs. Johnson for bringing to the attention of the House the efforts of the Auxiliary, and it further indicated a new appreciation of the importance of their activities and contribution to the preservation of the voluntary health system in this country.

HOUSE OF DELEGATES ACTION—Accepted the report of the Woman's Auxiliary as recommended by the Reference Committee.

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PRESENTATION OF CONTRIBUTION TO THE FOUNDATION—1961–1962

By the Wisconsin State Medical Assistants Society

Mrs. Julia Logerquist, Sturgeon Bay, president of the Assistants Society: I am happy to have this opportunity to appear before the House of Delegates in behalf of the Wisconsin State Medical Assistants Society.

Some of you may ask, "Who are the Wisconsin State Medical Assistants?" We are a group of girls organized statewide in 1955 and nationally in 1956, to better ourselves in self-improvement and in efficiency to our doctors and to their patients.

It is written in our Constitution that we will never become a part of a bargaining agency in any way or form; in fact, we would be penalized by losing our membership in the organization if we did.

We have held three educational symposia to date, and to date we also opened three courses in vocational schools within the State. We are hoping to open more in the near future.

On April 8 of this year it was decided by our Executive Board that this donation of $500 be made to the Charitable, Educational and Scientific Foundation of the Wisconsin State Medical Society for the Student Loan Fund, to help further our educational program.

Doctor Stovall, may I present this check to you.

William D. Stovall, M. D.: Thank you very much for this contribution to the work of helping us create more doctors. We really need them.

I would like to say just a word about those around us who are helping us carry on the practice of medicine. It is through their efforts that they meet our patients; it is through their efforts that they organize the many industries which go on in the doctor's office every day. As science advances these industries increase. Without their help we would not only be lonely but we would be less efficient.

Thank you very much for the check.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the report of the Wisconsin State Medical Assistants Society. The Committee also acknowledged the interest of the Assistants Society in the financial needs of medical students, and thanked them for their generous support of the Foundation's programs in this field.

HOUSE OF DELEGATES ACTION—Accepted the report of the Wisconsin State Medical Assistants Society as recommended by the Reference Committee.

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PRESENTATION OF POSTHUMOUS AWARD—1961–1962

Honoring E. D. Schwade, M. D.

Mr. Stuart H. Becker, Madison, chairman of the Governor's Committee on Employment of the Handicapped: As Chairman of the Governor's Committee on Employment of the Handicapped in the State of Wisconsin, it is my distinct privilege this evening to bestow a posthumous award as Physician of the Year upon Dr. Edward Schwade.

Doctor Schwade's many activities on behalf of the former mental patient, epileptic, mentally retarded patient, and other handicapped persons has had a direct effect on the employability of these persons in Wisconsin. Doctor Schwade gave excessively of his mental and physical reserve to help people, most of them plain people, many of them without hope, to attain a semblance of security, personal happiness and a place in society with gainful employment.

He appeared frequently before the State Legislature on laws which discriminated against the epileptic citizen. His appearances before the Wisconsin Legislature resulted in a modification of the driver's licensing law to permit certain epileptics to drive, and further, a law to insure the validity of marriages of certain epileptics.

In addition to being a member of the Governor's Committee on Employment of the Handicapped since 1959—and incidentally both Doctor Schwade and I were appointed to this Committee by the former Governor, Walter Kohler—Doctor Schwade belonged to almost every other organization relating to his highly specialized field of medicine.

As a physician, Doctor Schwade fully realized the social and economic relations essential for the return of his patient to a normal life, as is obvious in his wide range of activities. He did not consider medical treatment an end in itself. The rehabilitation of the individual, education within his profession and the lay public, the removal of discrimi-

natory laws, all were equally important on the basis of his outstanding record of service.

As Chairman of the Governor's Committee on Employment of the Handicapped, I hereby wish to bestow this posthumous award as Physician of the Year upon the late Dr. Edward D. Schwade.

L. F. Jenk, M. D., Milwaukee, representing the Wisconsin Psychiatric Association: Thank you Mr. Becker. This award for the deceased Dr. Edward D. Schwade is one appropriate indication of the devoted and dedicated service one of our medical colleagues rendered during his lifetime.

Doctor Schwade's efforts in the field of neurology and psychiatry have been indicated here and are a matter of record, for his activities not only in Milwaukee but in the State of Wisconsin and on a national plane. This award is accepted on behalf of the Wisconsin Psychiatric Society and the Milwaukee Neuropsychiatric Society, and on behalf of his medical colleagues. It is being requested that this recognition, this award, be placed in the Hall of Fame in the State Medical Society building.

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REPORT OF THE COMMITTEE ON HEALTH ECONOMICS OF AMERICAN LIFE—1961–1962

Robin Allin, M. D., Madison, Chairman

You are very lucky this evening because you are going to be spared an off-the-cuff speech. Doctor Fox has stolen my speech and has done a much better job than I could have done, as you would expect.

I would simply like to say that in the fall of 1960 your State Medical Society belatedly realized that doctors should orient themselves and think in terms of politics, think in terms of legislation, particularly legislation that concerns medicine and concerns our American way of life. And so there was born the Federal Legislation Committee, subsequently known as HEAL. It was formed at that time particularly because the Federal government developed a resurgence in its feeling as regards socialization of medicine in the United States. So, we felt it incumbent that medicine take a closer look in the hope that we could avert what has happened in England and which they have now learned to regret.

As a result, most of our efforts have been expended in talking and writing and petitioning our congressmen and doing everything we could to express our opposition and the opposition of our friends—personal friends, friends in business and friends in other professions—to government interference in medical practice in the United States.

I have recently returned to Washington, where, as you know, the situation is nip and tuck in the House Ways and Means Committee. Congressman John Byrnes, who is our senior Republican member of the House Ways and Means Committee, told me last week that they still had the majority vote to hold it in committee, but he didn't know how long that was going to last because of the increasing pressures from the Administration, and he felt there would be very definite action on this bill after the tariff bill has been disposed of in the next several weeks.

Of course the Administration is focusing its attention on getting a maximum effort on petitioning congressmen from especially the Golden Age Clubs throughout the United States so that the impact will come at the right time on May 20, and then a week later with the meeting in Washington of the Golden Age Clubs, at which time they hope to present hundreds of thousands of petitions and overwhelm the congressmen and make them feel that this is the voice of the people, that this is what they want, when you know and they know that the majority of people really don't want it if they only understood it.

So, it is essential that we become enlightened and that we lobby and that we elect to office those people who believe in the American system of free enterprise. We can't do very much with those congressmen who are in Washington who have already spoken very strongly in opposition to our views, so we must have them removed from office and we must put people in who think the way we think.

Within the last week the various county medical societies and individuals have received detailed suggestions on what they can do as individuals, what they can do as societies, what they can get their friends to do as individuals and other organizations, to create an impact of our own on Washington come May 20–25 so that we can defeat the Administration's proposal to begin socialization of medicine.

You have received this information, and you will receive tonight a detailed check-off list for individuals. I wish you would read it over and check it off as you honestly feel you can. Have you done this? Will you do it? Will you help your State Medical Society? It is doing all it can. HEAL is doing all it can. This is not just our fight—it is your fight and everybody's fight. So, will you please check off this list; and if you haven't done everything on it that it says you can do to help us accomplish our purpose, then please do it between now and May 25.

Also, shortly after President Kennedy's television broadcast on May 20 your State Medical Society, through its Council, has authorized the HEAL Committee to use statewide press releases and advertisements in an effort to invite people and hope people will lobby and petition and help us to elect the right people to office.

I would like to say in closing that there was a quotation in the first Hoover Report on Government Reorganization, saying that the power of the scepter of a king is nothing as compared to the power of a 5-cent pencil in the hand of a constituent who is petitioning his legislator. Senator Kerr has said, "The night you sleep will be the night that the Administration will pass the King-Anderson bill."

Now, Mr. Speaker, I would like to have the privilege of the floor for the purpose of making an announcement. This is purely an announcement, but it is a very important one because it concerns you as individuals, not as doctors but as people who believe in free enterprise and who believe that we should elect to office those people who also believe in free enterprise.

To that extent, a group of us have formed in Wisconsin a Political Action Committee, which Doctor Fox has alluded to, which is a joint member with AMPAC. I give this to you simply as an announcement because you as a body cannot act on this, as it is against the law for you to do so because you are a corporation that cannot engage in political action. However, as individuals you certainly can.

This WISPAC organization was formed for the purpose of promoting and striving for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in government affairs, to encourage physicians and others to understand the nature and actions of their government as to important political actions and issues, and to the records of officeholders and candidates for elective office, and to assist physicians and others in organi-

zing themselves for a more effective political action and in carrying out their civic responsibilities.

We have two classifications of membership—an Active membership at $25 and a Supporting membership of under $25, which I don't want to talk about, and a Sustaining membership of $99.99. It has to be under $100 or you have to report it to the Internal Revenue Bureau as a contribution.

I have a lot of membership blanks here tonight, and I also have these little stickers that I will be glad to stick on your coat lapel to show that you are backing WISPAC because we need money. We need money now to help elect the proper congressmen from Wisconsin and to also help AMPAC help elect congressmen from strategic areas throughout the counties.

REPORT OF REFERENCE COMMITTEE ON STANDING COMMITTEES—Complimented Doctor Allin for his oral report and for his generous contributions of time and effort in behalf of the Wisconsin Professional Political Action Committee (WISPAC). Urged each physician to take an active role in the WISPAC program of political action and education. Recommended acceptance of this report.

HOUSE OF DELEGATES ACTION—Accepted the report of the Committee on Health Economics of American Life as recommended by the Reference Committee.

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REMARKS OF ROBERT PURTELL, M.D., MILWAUKEE

At the annual meeting of the American Academy of General Practice held in Las Vegas in April, the Oklahoma Chapter of the Academy presented a plan which was adopted and which, incidentally, has been adopted and implemented by the Wisconsin Chapter in an effort to defeat the socialistic King-Anderson bill in its plan for medical care of the aged.

I have only one copy, and I will read it and then pass it around so the delegates may all see it. The plan is very simple. It is a placard which is placed in the physician's waiting room. His receptionist is simply asked to have the patients read this placard. I will read it to you:

DO YOU WANT THE GOVERNMENT TO CONTROL YOUR MEDICAL CARE?
FREEDOM IS A PRICELESS HERITAGE

When you lose the right to choose the doctor you believe best for you, you lose an important personal freedom. Your right to life, liberty, and the pursuit of happiness is in peril.

FREEDOM BELONGS TO EVERY AMERICAN

In order to provide the best medical care, your doctor must be free to adapt his knowledge and skills to your personal medical problem and those of each member of your family.

GOVERNMENT CONTROL MEANS SOCIALIZED MEDICINE

When an agency of the Federal government enters the privacy of the examination room, operating room, delivery room, and in all phases of patient care—even selecting your physician—the doctor's responsibility of "I will hold in confidence all that my patient confides in me" is substituted by "public record."

If you agree government control of medicine is another loss of your freedom, please sign the petition below.

The doctors are supplied with these petitions, and it reads very simply:

I, the undersigned, am opposed to government control of medicine in our free America. I favor free choice of my physician and voluntary insurance. I hereby petition you, Senator Kerr, Senator Monroney, and all congressmen in our State (and here they are named), to oppose any further government control of medical care.

s/ _____
Name

_____
Date

_____
Address

I can tell you very briefly how this plan will operate. Oklahoma is not a very populous state, nor are there a great number of doctors there as compared to Wisconsin. Within the first six weeks of its operation, over 30,000 signatures were secured by this rather simple means.

A doctor member of the Oklahoma Academy of General Practice and a receptionist were selected, and these petitions were personally delivered to the Oklahoma congressmen in Washington, D. C. These petitions had a very signal impact on the congressmen.

We are all too busy to talk to our patients and to try to explain to them just what the King-Anderson bill means to them. This is a very simple message. It was carefully composed by physicians, and it has worked out very well.

The Wisconsin Academy of General Practice is going to initiate this plan immediately. We appeal to all doctors in this State, and particularly to the members of the State Medical Society, to give careful consideration to this plan. We believe that if enough signatures are obtained—and an average doctor seeing 20 patients a day, 5 days a week, means 100 patients; multiply it by 2,000 doctors in Wisconsin and it means you have 200,000 signatures per week.

This is a tremendous plan. I am personally very enthusiastic about it. The Oklahoma doctors to whom I spoke told me that The Houston County Medical Society appealed to them for 500 copies of this placard and the petitions, and they are being sent to Houston.

I will pass these around. I don't want to delay your business tonight, but we are fighting socialism, and I think time is running out very rapidly. So, I urge you to adopt this and make a crash program of it. Get started on it rapidly.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended that the State Medical Society support this excellent addition to the program proposed by the Council and the Committee on Health Economics of American Life (HEAL) for public education and action on the King–Anderson bill by making these petitions and placards available to every physician for his own use.

HOUSE OF DELEGATES ACTION—Accepted the recommendation of the Reference Committee.

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REPORT OF THE STATE HEALTH OFFICER—1961–1962

Carl N. Neupert, M. D., Madison

That this constitutes the 20th year of relationship with the State Medical Society in my official capacity is gratifying personally, but is of much

more significance as a reflection of a good working relationship between the State Medical Society and the State Board of Health. Our common concern is the promotion of the health of the people we serve.

This relationship, of course, goes way back to the origin of the State Board of Health in 1876 when a physician in Sauk County, Doctor Teale, with the help of the State Medical Society, convinced the legislature of the need for a state health agency.

There have been many very significant accomplishments as a result of that relationship over the years. For instance, the matter of saving of lives of mothers in childbirth. In 1930, with *56,000 births* there were *298 maternal deaths* as compared with *27 maternal deaths* 30 years later, in 1960, when there were *100,000 births*. We in the State Board are proud of our role as a catalytic agent (particularly Dr. Amy L. Hunter of our group) and of *you* who really "carried the ball" through your maternal mortality studies, your postgraduate education program and your carry-through on the part of individual physicians as you extended devoted prenatal and maternity care to your patients. Over 99 per cent of those deliveries are now performed in hospitals.

We could point to many other accomplishments such as virtual disappearance of fatalities due to communicable diseases for which there are vaccines, such as diphtheria and now polio.

But, as a consequence of preventing deaths in younger age groups, etc., there comes the increase in proportion of our population referred to as an aging population. This is an accomplishment that is accompanied by increased incidence of chronic disease with approximately twice as much hospital utilization and incidence of illness for this age group as compared with those under age 65.

These are days of tremendous advancement in medicine and public health as a result of research. A few raise questions as to involvement of an official agency in the practice of medicine. As we move forward together to meet new challenges, may I reassure you that we won't go beyond our official responsibilities and even *within* those borders, we will rely heavily, as we have, on your expert help through advisory committees, etc.

Now that oral polio vaccine is becoming available, we are receiving inquiries as to policy concerning its use. Factors such as community-wide immunization programs, the approach of the polio season (July-October), lack of adequate vaccination especially of those under 5 years of age are among those being referred to. New York, Illinois and Minnesota have issued policy statements.

A week from tomorrow an advisory committee to the Board will tackle the matter of preparing a recommended policy for our state. On that committee are a representative of the State Medical Society, of the Academy of General Practice, of the Academy of Pediatrics, of the University of Wisconsin Pediatric Department, of the Wisconsin Association of Osteopathic Physicians and Surgeons and of three local health departments.

Important as those recommendations can be to a constructive approach to meet the problem to the benefit of the people we serve, they may have another significant bearing. Next week there will be heard before a committee in Congress a bill to provide Federal funds to support activities of state and local communities in intensifying and expanding present efforts to immunize the unprotected population. It is known as the Vaccination Assistance Act and involves immunization against polio, diphtheria, tetanus and pertussis with Federal funds available for the purchase of vaccines for those under 5 years of age. We are advised that under the bill vaccine for children under 5 can be provided to private physicians for office use as long as free clinics are also available. Should this bill be enacted, we would need to get together on how to proceed in our state.

Were there time we could review many other joint approaches to public health problems. Together we're doing rather well—let's keep it that way. We'll try to do our part and we're sure you will do yours.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the report of the State Health Officer with the following comments: Doctor Neupert's statements concerning a statewide policy on the administration of oral polio vaccine and proposed Federal legislation in the field of immunology were extensively discussed. It was the feeling of this Committee that any such proposals be carefully reviewed by a committee of the Council, and that a statement of policy be issued as a result of its study. The Committee strongly urged that any program have its control at the local level. The Committee further recommended continued cooperation of physicians with Doctor Neupert and the State Board of Health.

HOUSE OF DELEGATES ACTION—Adopted the report of the State Health Officer as recommended by the Reference Committee.

REPORT OF SECRETARY OF STATE BOARD OF MEDICAL EXAMINERS—1961–1962

T. W. Tormey, Jr., M. D., Madison

At the last meeting with this House I mentioned the program for licensing foreign graduate physicians. Included in that program is a Board ruling requiring the foreign graduate to furnish one or more letters requesting his or her services by some clinic, community or institution. The purposes of the rule are to help us to be as sure as possible that the individual is needed and will have a specific location in which to practice—thereby obtaining the greatest benefit of this source of medical attention for our citizens. We are, as you know, limited to licensing not more than 25 such individuals in any year. Feeling it would be of interest to follow up some of this group, a survey of the last 60 licensed prior to 1962 was made. Forty-one are in their original locations—24 of these in state or county institutions or associated with clinics or medical schools. Eight have since moved to another location in Wisconsin. More surprising, in view of their apparent and avowed eagerness to settle in this state, 4 never settled here and 7 left for other states within a short time.

For a moment let's look at the foreign graduate in the residency training programs under the Temporary Educational Permit Law. The numbers of this group are now diminishing, probably largely due to the requirement that they pass the examination conducted by the E. C. F. M. G. This examination is intended to assure a higher calibre individual serving in house staff positions. To maintain their approved status, hospitals must see to it that their foreign resident trainees have obtained a certificate from the E. C. F. M. G. An indication of the depletion in the number of these individuals will be found in the following figures. In 1959 there were 50 new applicants and 40 renewals; in 1960 there were 50 new applicants and 27 renewals; in 1961 there were only 28 new applicants and, up to this date, only 2 renewals. How many American graduates fill the vacant positions I don't know, but at first glance it would appear the training programs and hospital patient care are suffering for lack of personnel.

A number of legislative changes were accomplished in the past session. Briefly these were as follows:

(1) The foreign graduate who meets all requirements and has a license to practice on the basis of a written examination in another state may now be interviewed on a reciprocity or endorsement basis. Previously we were unable to do this.

(2) A temporary license may now be granted an honorably discharged surgeon of the Armed Services of the U. S. or of the Federal Public Health Service who meets the other statutory requirements.

(3) The Board may temporarily suspend a license or certificate of registration without formal proceedings, and place the holder on probation for a period not to exceed three months where the Board has reason to believe there have been violations of 147.20 (1), Wis. Stats. No more than two consecutive three-month periods of the above action may be used in any given instance.

Occasionally apparent violations of the Medical Practice Act as pertains to industrial injuries are reported to us for our consideration. Because of several such reports a meeting was held with representatives of the Industrial Commission and the Board of Nursing for the purpose of establishing liaison with those groups and discussing medical treatment in industrial plants by other than licensed physicians. This last not uncommonly occurs. A spirit of cooperation and an expression of a mutual desire to insure proper care of the industrially injured came out of this particular meeting.

Investigations of complaints of other violations made to our office have been concerned with 20 physicians, 18 quacks, 2 podiatrists and 1 masseur. The illegal use of drugs involved 7 individuals; 14 additional or review investigations were made.

Of this group we have secured the revocation of one license by court action and the voluntary surrender of two others. Three physicians have surrendered their narcotic stamps under the direction of the Treasury Department. One action pending is the injunction proceeding against "faith healers," and if we prevail, we may see an end of this type of treatment in Wisconsin. The so-called Scalp Specialists must stay within the cosmetology law and conferences with them have resulted in several going out of business and others agreeing to modify their advertising and eliminate references to diagnosis and treating diseases of the hair and scalp.

In the past year we have issued 333 licenses or certificates. Of this group 298 were to physicians, 33 to physical therapists and 2 to podiatrists.

To date we have a total registration for 1962 of 6,174 individuals. Breaking this figure down we find—

5,436 M.D.'s	4,250	in state
	1,186	out of state
230 D.O.'s	135	in state—unlimited
	39	out of state—unlimited
	12	in state—osteopathy & surgery
	36	out of state—osteo. & surgery
	8	in state—osteopathy only
370 Physical Therapists	230	in state
	140	out of state
138 Podiatrists	138	in state

We expect the new register will be out soon and sent to all who registered.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Commended the work of the State Board of Medical Examiners and recommended acceptance of the report of the Secretary, Doctor Tormey.

HOUSE OF DELEGATES ACTION—Accepted the report of the Secretary of the State Board of Medical Examiners as recommended by the Reference Committee.

REPORT OF COMMISSION ON STATE DEPARTMENTS—1961–1962

T. W. Tormey, Jr., M. D., Madison, Chairman

Aging ——— A. M. Hutter, M. D., Fond du Lac
Chest Diseases ——— H. A. Anderson, M. D., Stevens Point
Handicapped Children ——— J. W. Nellen, M.D., Green Bay
Maternal & Child Welfare ——— J. R. Evrard, M. D., Milwaukee
Nervous & Mental Diseases ——— K. M. Keane, M.D., Appleton
Public Assistance ——— H. W. Carey, M. D., Lancaster
Rehabilitation ——— Ray Piaskoski, M. D., Milwaukee
Safe Transportation ——— R. B. Windsor, M. D., Sheboygan
School Health ——— L. M. Simonson, M. D., Sheboygan
Visual & Hearing Defects ——— M. S. Fox, M. D., Milwaukee

RECOMMENDATIONS

1. The Division on Safe Transportation recommends that the State Medical Society of Wisconsin support the establishment of a Highway Safety Center at the University of Wisconsin.

2. The Division on Safe Transportation urges that the State Medical Society of Wisconsin move ahead with legislative action to amend the Statutes so as to apply the Criminal Code definition of "under the influence" to dangerous drugs as well as narcotics and alcohol as these relate to the operation of a motor vehicle.

3. The Division on School Health recommends that the State Medical Society of Wisconsin urge colleges and universities in the state to provide more extensive health education to students preparing for careers in teaching.

4. The Division on School Health recommends that county medical societies be urged to have a panel available to fill requests from school administrators for speakers on school health, and that they encourage meetings on the community level between physicians and school administrators to discuss common problems in the health and fitness of school age children.

5. The Division on School Health recommends that school administrators in Wisconsin be urged to develop modified physical education programs so that no student able to attend school be excused from physical education. The extent of physical activity desirable for any student remains a matter for recommendation by his physician.

INTRODUCTION

When, in 1954, the House of Delegates acted to create the Commission on State Departments as an amalgamation of several then existing committees,

MEDICINE AND SURGERY IN THE CIVIL WAR, Drs. William G. Gallagher and Edward Perry, Skemp Clinic and The Adolph Gundersen Medical Foundation, La Crosse. During recess periods, slides made from photographs, line drawings, and etchings of Civil War physicians, aid stations, field hospitals, hospital trains, and hospital ships were shown. The pictures coincided with the chronology of the war. There was a preliminary series of slides showing the general medical situation in the mid-nineteenth century in Europe and America.

the principle of administration-by-commission was seldom used by medical societies. Today, however, many societies have found this method of committee activity an effective means of maintaining continuity and coordination between independent but related committees of the medical society and a variety of governmental and voluntary organizations whose interests overlap those of medicine and public health.

It is pleasing to note that during the past year, four state medical societies have made formal inquiry of the State Medical Society of Wisconsin concerning the operation of its Commission on State Departments. The success of the Commission in establishing and maintaining close relationships with state agencies and voluntary health agencies is attested in part by the regard in which its activities are held by others outside the borders of the state.

Whatever plaudits might be acknowledged for past accomplishments, the Commission realizes its task as a coordinating and advisory body is growing rather than diminishing; becoming more complex rather than more simplified; and consistency is more difficult of achievement as health activity expands in government operations.

Recent years have seen the development of health bureaucracy in the Federal government at an alarming rate. More than 60 different Federal agencies render Federal medical services. Developments within the state government are neither as marked nor as dramatic. Yet, they are expanding with considerable rapidity; and it appears that a fully realistic appraisal is needed so that the medical profession may keep abreast of current programs, in advance of current trends and in a position of leadership for the health of the public.

Wisconsin physicians pioneered many of the health programs now regarded as "must" activities within state governments. Those instrumental in developing such programs have in many instances left the scene. The philosophies of the founders have sometimes become diluted or diverted; not only from lack of continuity, but also by the impact of changing times and methods. And specialization has come to government as it has to medicine, bringing with it the same weakness: the tendency to serve in one specialized field without full realization of the part that particular field plays to the total health and medical care picture.

As health has become increasingly a legislative matter, with occasional political overtones, it is inevitable that administrative authority and decision make itself felt in areas hitherto free of governmental regulation. Soundly applied, administrative rules can be an important force for progress and patient welfare. Injudiciously used, administrative power holds the possibility of placing professional judgment in a straight jacket and artificially eliminating differences between the ordinary and extraordinary in human health situations.

For some years the Society has considered the advisability of a thorough analysis of the administrative codes of the many state agencies and departments whose activities touch on health care of the people of Wisconsin. The Society has recognized its responsibility; time and budget and other pressing problems have deferred the study.

The Commission on State Departments believes that such a study is urgent. It should include not only the administrative codes of the various state agencies, but also their relationship to the statutory provisions from which authority is derived. The Commission recommends that this study be undertaken in the near future with a progress report, and if possible, a final report to be presented at the 1963 regular session of the House of Delegates. The Commission further recommends that each of its ten divisions defer to the completion of this project the initiation of any new and nonemergent activities, concentrating their efforts instead on participation in those portions of the study relative to their respective interests. This action will enable the Society to obtain a much needed view of the whole health care picture in government, and to chart a course of greatest assistance to the health of the public.

AGING

The Division on Aging is cooperating with the Commission on Scientific Medicine in preparing a Conference on Medical Aspects of Caring for the Aging Patient. While this conference is only in the preliminary stages, it is felt that an appealing program can be developed for physicians in cooperation with the Wisconsin Academy of General Practice, the State Board of Health, the Department of Public Welfare and other groups and agencies.

A Wisconsin Conference on Home Care is also under discussion. Such a meeting would seek to define "home care" needs in Wisconsin, arrive at understanding of the terms "home care" and "home nursing care" and outline programs for the development of reasonable home care services in the state.

Members of the Division have been active in attending the Regional Workship on Home Care (Chicago, May 24–26, 1961), the National Conference of the Joint Council to Improve the Health Care of the Aged (Chicago, December 15–16, 1961), and a series of regional meetings for nursing home operators held in southern Wisconsin.

The State Commission on Aging, created by the 1961 Legislature, has announced a plan to inventory the resources of the aged (*The Capital Times*, March 23, 1962) including "their major problems affecting house and home, use of time, work, health and economic security." The Division has great interest in this study and is considering special recommendations for Society action.

The Division is currently consulting with the Wisconsin Council of Homes and Hospitals Serving the Aged, Inc. (non-profit and governmental homes for the aged) to assist it in the development of medical staff standards as part of an over-all accreditation program. These will be reported to the Commission prior to final recommendations.

County medical societies should continue to take a leading role in developing community understanding of the problems and opportunities for elderly citizens. Further guides for such activity are available from the Division on Aging, and the Division especially recommends four new publications of the American Medical Association for the use of committees on aging within local societies. These publications are:

1. "How the Older Person Can Get the Most Out of Living."
2. "Ways in Which Younger and Older Adults Can Improve and Maintain Their Health."
3. "Education of Children for the New Era of Aging."
4. "A. M. A. Position on Employment of Older People."

CHEST DISEASES

During the past year the Division on Chest Diseases has directed its major attention to the continuing program of the State Board of Health in reference to hypertension detection through the operation of the mobile units, and action of the 1961 House of Delegates requesting the State Medical Society to enlist the assistance of the Governor and the Legislature in the initiation of an extensive study as to the care of tuberculous patients in Wisconsin, including the operation of sanitoria facilities. This matter was incorporated in a resolution introduced by the Douglas County Medical Society, and was referred by the Council to the Division for further study, with the request that a report on this matter be made to the 1962 House of Delegates through the Commission on State Departments.

The Division has met with representatives of the Douglas County Medical Society, and has given serious consideration to the matter referred for study. The Division has on past occasions called attention to the desirability of centralizing care of the tuberculous into institutions which are particularly staffed for this purpose, as is being done in Milwaukee County. However, it is recognized that in Wisconsin consolidation of county facilities rests with the action of county boards. A full report on this matter was made to the 1959 House of Delegates, and the Division's views on the subject in 1962 coincide with the views expressed at that time.

The Division is aware of the fact that the State Board of Health is planning to undertake an exhaustive survey of the entire situation in respect to tuberculosis control and patient care. In light of this impending study, and assurance that the State Medical Society will be asked to actively participate in the survey, the Division recommends through the Commission on State Departments that for the present this matter be held up as to further action of the House of Delegates, and that the Division report on this as the State Board of Health survey is completed.

Hypertension Screening Program

In previous reports the Division has commented upon the pilot study of the State Board of Health incorporating hypertension screening as an adjunct of x-ray screening through use of the mobile units. This program has been conducted only in counties which have agreed to have the testing done. Since 1959 when the program began, 63 counties have approved the pilot program. In 1960, screening was done in 14 counties plus the city of Milwaukee (and eight counties did not accept hypertension screening as part of the x-ray program). While statistics on all areas screened in 1960 were not available when this report was prepared (April 1), the experience in Public Health District 4 might illustrate the importance of this program. Of the 10 counties in District 4, screening was done in eight (Buffalo, Trempealeau, Jackson, La Crosse, Monroe, Juneau, Sauk and Vernon). Crawford and Richland did not participate. Of 27,237 persons screened, 25,235 gave a negative history of heart disease or suspected heart disease (2,002 gave a positive history, and were not referred after being tested). 810 or 3.2% of those giving a negative history showed abnormal blood pressure, and it was suggested they consult their family physician for a further evaluation. Of these 810 individuals, 590 or 72.8% were followed up, and of these 447 or 77.5% were confirmed to have heart disease, *though unsuspected on the part of the patient and unknown to the family physician.*

The Division feels these findings have significance and suggest value in the program. It will continue to evaluate this pilot study and report its recommendations.

TB Is Still With Us

The Division on Chest Diseases wishes to stress that in spite of new drugs, the control of tuberculosis is still a public health problem. While reported cases have shown a decline, in 1960 there were 1,085 reported cases of tuberculosis in Wisconsin.

Reliance on drugs for ambulatory care has led to a general feeling on the part of the public that tuberculosis is one of the "conquered diseases." This very relaxation can lead to a spread of the disease, as ambulatory care is only effective when drug regimen is strictly maintained. It should be the responsibility of every physician treating tuberculosis to make sure that patients are periodi-

cally re-evaluated and to have assurance that his instructions as to the continued use of prescribed drugs are being scrupulously followed. Only in this way can we hope to show an actual improvement of our statistics in Wisconsin.

The Division is pleased to report the finest of cooperation with staff members of the State Board of Health who are responsible for the tuberculosis control program. The Division feels sure that by cooperative effort of physicians and public health officials further significant progress in the area of tuberculosis control can be achieved.

HANDICAPPED CHILDREN

During the past year the Division on Handicapped Children has continued to work cooperatively with the Bureau of Handicapped Children of the Department of Public Instruction in all phases of the Bureau's work, associated with medical care.

The Orthopedic Clinic Program

For many years the Bureau has conducted orthopedic clinics in counties requesting this service. With the growing number of full-time orthopedists located in various parts of the state, the over-all need for this program has changed in character. Working with the Bureau, the Division has studied local situations, and in areas where orthopedic services exist, and where the county society has expressed a desire to discontinue orthopedic clinics, the service has been eliminated from the work of the Bureau. This has occurred in Brown, Fond du Lac and Outagamie Counties. The Bureau has been most cooperative in this regard, and has merely been concerned with the welfare of the children heretofore served by the clinic program. Studies of local situations where clinics have been eliminated indicate that children needing care are being well cared for through the services of orthopedists in the immediate area. In 1960 twenty-six clinics were held at fourteen centers at the request of the county medical societies involved.

Bicillin Program

During the past year the Division has given special attention to meeting the objections raised at the last meeting of the House of Delegates concerning the Bicillin program operated through the Bureau. The program has been revised so as to clarify some of the misunderstandings which arose concerning the manner in which a patient might qualify for the program, and at the same time to give assurance that there is financial need involved. When a patient is placed on the program by recommendation of the family physician, all that is required is a periodic medical report to show that the patient is being seen by the family physician and fundamental tests made to indicate the need for continued use of the drug. Currently about 1,200 children are receiving Bicillin under this program.

Other programs under the direction of the Bureau are regularly reviewed with the Division, and any question of medical policy discussed. The Division is pleased to report a most harmonious relationship with the Bureau and its medical advisor, Dr. Patricia McIllece.

MATERNAL AND CHILD WELFARE

The Division on Maternal and Child Welfare is pleased to report the continuation of several projects and the initiation of new teaching programs which have been well received by members and selected hospital personnel, since the House last met.

Maternal Mortality

The Maternal Mortality Survey is in its seventh year of operation, and it continues to produce invaluable information which is transmitted to physicians and hospitals through bulletins, articles in the *Wisconsin Medical Journal*, and special teaching programs. This past year two programs on this subject were held in Madison and Wausau in cooperation with the Madison and Wisconsin Valley Chapters of the Wisconsin Academy of General Practice. The programs were well attended, and caused many favorable comments among the generalists who participated. Indirectly, the subject of maternal mortality was introduced into special conferences on "Care of the Newborn" in Wausau and Green Bay, and in the various Prematurity Institutes outlined in detail following. The Maternal Mortality Survey is one of the most significant teaching projects of the Society, and has been well received by all physicians in the state, who understand its basic purpose as education rather than "investigation."

Pitocin: A Subject of Discussion

One subject which constantly presents itself for discussion in every Maternal Mortality Institute is the recommendation of the Division as to the use of Pitocin in the stimulation of labor. The Division wishes to reiterate its position as expressed in 1959 (*Wisconsin Medical Journal*, September, 1959, pages 7–8) and approved by the Council:

1. ". . . The administration of 'Pitocin,' or any oxytocics, in relation to obstetrics is a medical procedure which should under no circumstances be delegated to the nurse or other non-medical personnel without direct and continuing medical supervision. . . by 'direct and continuing supervision' we do not mean that the physician must stay by the bedside of the patient continuously until labor has been completed, but we do know that the action of 'Pitocin' is of such a varying nature that it may present emergencies which are beyond the scope of the nurse to properly meet. If the administration is ordered he (the physician) should be in attendance at the time the oxytocic is administered, and he should either be in direct attendance of the patient until after delivery or be in such close proximity to the patient that he can be reached and provide attention to the patient within a few minutes after an obstetrical emergency arises." (Since expressing this position, the Division is aware of the fact that emergencies arise which require the physician to leave the hospital, in which event some *medical* coverage is indicated.)
2. ". . . The risk of the intramuscular administration of the drug creates greater risk, since when once given, it cannot be retrieved, and therefore cannot be controlled. Even when small repeated doses are administered intramuscularly, the effect cannot be predicted because of disparity between individual patient's response and variable standardization of the drug. Administration by means of dilute intravenous drip method also carries a calculated risk, but has a greater safety factor since the rate of utilization can be controlled, and its effect terminated by discontinuing the flow of the intravenous solution.

There has been enough evidence to make the Division feel the foregoing regulations by the medical staff of a hospital are not unreasonable, and

are essential to give the patient the protection needed whenever Pitocin is employed for the induction of labor.

It is felt by those closely associated with the Maternal Mortality Survey, that continued emphasis upon special problems highlighted by the study has assisted many physicians in meeting obstetrical emergencies in an increasingly effective manner. Likewise, making the findings of the Survey available to hospital personnel has resulted in an alertness on the part of nurses, which has undoubtedly contributed to the saving of lives among the obstetrical patients served.

Infant Deaths

The Division has called attention to the continuing problem of infant (children under one year of age) deaths. Reports from the State Board of Health indicate that Wisconsin's experience (23.4 infant deaths per 1,000 live births) is somewhat below that of the national average (25.7 per 1,000 live births) in 1959. Although national figures are not available for 1960, the State Board of Health reports that Wisconsin's rate has improved to 22.3 per 1,000 live births in that year.

While Wisconsin has a relatively favorable record, the Division believes it should be of general concern that out of 99,413 live births in Wisconsin in 1960, a total of 2,163 children died under one year of age. The chief causes were prematurity, birth injuries, atelectasis and asphyxia, congenital malfunctions and pneumonia.

Recognizing this as a continuing medical problem, the Division has suggested that hospital staffs make infant deaths a subject of study. Some of the larger hospitals in Wisconsin have undertaken studies of this kind, but there is still need for greater cooperative effort on the part of medical and nursing staffs to further improve this situation. The Division has been pleased to present two special teaching conferences on "Care of the Newborn" in Wausau and Green Bay this past year. Both programs were developed cooperatively with the local chapter of the Wisconsin Academy of General Practice and the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. Three hundred and six persons attended these meetings (138 M. D.s and the balance nurses from 34 Wisconsin hospitals), and from comments, it is apparent that meetings of this kind have value and should be continued.

Institutes on Prematurity

As a correlary of the Division's major concern with infant deaths, attention has been directed to special medical and nursing problems associated with prematurity. Seven conferences have been held on this subject this past year. With the State Board of Health as joint sponsor, conferences have been held in Viroqua, Sheboygan, Milwaukee, Appleton, Dodgeville, Park Falls, and Rice Lake. More than 500 persons have attended these meetings, with the majority of hospitals represented by both physicians and nurses. These meetings have emphasized the "team approach" to premature care, and have alerted physicians and nurses alike to special problems of care which confront them in reference to premature births.

The Division is aware of many problems which warrant discussion and later reporting to the House of Delegates. Medical problems of adoption agencies, (including basic studies to establish eligibility on the part of parents), is a matter of concern to many physicians and suggests study and recommendations. As new problems arise, the Division will be pleased to make recommendations to the House.

In closing this report, the Division wishes to acknowledge the help and cooperation of the Bureau of Maternal and Child Health of the Wisconsin State Board of Health. The director of the Bureau, Dr. James Wardlaw, has assisted the Division in all of its efforts, and through him the State Board of Health has provided valued financial assistance to reimburse speakers who have appeared on the various teaching programs outlined in this report.

NERVOUS AND MENTAL DISEASES

The Division expresses deep regret at the loss of its long-time chairman, Edward D. Schwade, M. D., of Milwaukee. His untimely death closed a career of devotion and determination to the cause of mental health, to equal rights and better care for epileptics, and to greater public and professional understanding of nervous and mental diseases.

A most active program has been assigned to the Committee on Commitment Laws of the Division. This Committee advises on a continuing basis with a special section of the State Mental Health Advisory Committee analyzing the commitment laws of Wisconsin and their implementation with a view to possible improvement by statute and voluntary means. The Committee has also had referred to it, and is now studying, the complex matter of policies relating to the commitment and release of the insane as exemplified in "The Case of Terrence Donovan." This study will be undertaken during 1962 and a report is expected before the next regular session of the House.

Hypnosis for entertainment purposes in schools drew the attention of the Division during recent months. News releases were issued warning of the dangers inherent in this abuse of a medical aid, and conferences were held with the State Superintendent of Public Instruction and many local school administrators. The popularity of entertainment-hypnotists is unwittingly enhanced by honest lack of appreciation by school authorities of the potential dangers involved. The Division strongly recommends adoption of a resolution encouraging the American Medical Association to provide authoritative information on this subject to physicians, educators and the public.

Concern has been voiced by the Division with certain trends in the development of the so-called "Action for Mental Health" program developed by the National Joint Commission on Mental Illness and Health. It feels that the recommendations are too broad and dogmatic considering that the Commission studied only the state and Federal institutional segment of the problem. Since the program will be the object of major discussion at the First AMA National Congress on Mental Health, October 4–6, 1962, the Division urges that the Society have strong representation at this conference through members of the Division, and that other Wisconsin psychiatrists and general practitioners be encouraged to attend.

The Division has made preliminary studies of driver licensing problems concerning persons released from mental institutions, but more detailed consideration is indicated before specific recommendations can be made. The study will be conducted jointly by the Division on Nervous and Mental Diseases and the Division on Safe Transportation in cooperation with state officials.

PUBLIC ASSISTANCE

Members of the Division on Public Assistance have been active in supporting efforts to implement the Kerr–Mills Act in Wisconsin, and will con-

tinue to promote this legislation. No other special problems have confronted the Division during the past year. However, it continues to observe the operation of health care provisions of the state's public assistance laws and encourages close liaison by county societies with local public welfare departments as a means of assuring effective programs in this field.

REHABILITATION

The Division on Rehabilitation has maintained liaison with the Department of Vocational and Adult Education and its Rehabilitation Division and has actively supported the Governor's Committee on the Employment of the Physically Handicapped.

With respect to the latter, the Division was proud to recommend to the Governor's Committee that it submit the name of Edward D. Schwade, M. D., Milwaukee, to the President's Committee for the Employment of the Physically Handicapped for consideration to receive, posthumously, the President's Award to a physician for outstanding work in rehabilitation. Although the determination of the President's Award has not yet been made, and regardless of the decision, Wisconsin recognition of Doctor Schwade's great work in epilepsy and mental health is a worthy and deserving tribute.

SAFE TRANSPORTATION

Crash Injury Research Study

On July 1, 1961, Automotive Crash Injury Research of Cornell University began a study of automobile accidents in Wisconsin, with the State Medical Society of Wisconsin as one of the cooperating agencies. The first phase of the study, covering accidents in the eastern half of the state, was completed December 31, 1961, and the second phase, covering the western half of the state, is presently in progress. On July 1, 1962, the third phase will begin. This will include reporting of accidents on automobiles five years old or less, involved in an accident where there is a death or injury. Accidents reported in the study are those investigated by an officer of the Wisconsin State Highway Patrol.

When such an accident occurs, separate reports are filed by the traffic officer and the physician who treats the injured person or the hospital in which the person is treated. These are transmitted separately to the State Board of Health where they are coded and subsequently sent to Cornell University for tabulation of the information.

The data so collected is primarily utilized in cooperation with automotive manufacturers to bring about design changes to eliminate those features which contribute to injury or death in an automobile accident.

The Division periodically reviews the progress of the study in Wisconsin and maintains close liaison with the staff of Automotive Crash Injury Research. It expects to make a report of results by early 1963.

Automobile Seat Belts

The 1961 Legislature passed the first law in the nation requiring installation of front seat belts in 1962 or later models sold in the state. Passage of this legislation culminated many years' efforts by the State Medical Society and its Division on Safe Transportation for such a law.

Since its passage, the efforts of the Division have been in public education to encourage *all* automobile owners to install this proven safety device and educate those who have the automobile seat belts to use them every time the auto is in motion.

Some of these public information efforts include: a news release pointing out that the new law is a major step in traffic safety, but that seat belts must be utilized by drivers and passengers; two radio programs encouraging the use of seat belts; distribution of the pamphlet "Seat Belts Save Lives" to all physicians in the state for use in their reception rooms; erection of an exhibit in the State Capitol encouraging use of seat belts; and exhibit at the Annual Meeting encouraging physicians to buy seat belts; use of a postage meter cachet on out-going mail of the State Medical Society advocating purchase and use of seat belts.

Establishment of Highway Safety Center

During the past year, the Division has encountered various areas of concern in which factual data on which to base decisions, particularly in specific reference to Wisconsin, is not available. This includes certification of former mental patients for re-issuance of drivers' licenses, need for more effective regulation of ambulances and ambulance personnel, driving performance records of individuals with visual and hearing impairments, and the relationship of mental attitudes and safe driving.

In the next few months, the Legislative Council will be considering the establishment of a Highway Safety Center at the University of Wisconsin. One of the functions of such a center would be gathering of statistical information on such topics as listed previously.

Dangerous Drugs

During the 1959 session of the Legislature, the definition of dangerous drugs was expanded to include all prescription drugs. The Statutes also provide for the loss of license of a driver who operates a motor vehicle while under the influence of dangerous drugs. "Under the influence" is defined by the Criminal Code as having such effect as "materially impairs judgment." As presently written in the Statutes, this definition applies only to the use of narcotics and alcohol in relation to the operation of a motor vehicle.

SCHOOL HEALTH

Educational Activities

In the past year, the Division has been active in helping present athletic injuries conferences and an institute for college health instructors. In November, 1961, 423 coaches, athletic directors and administrators attended five conferences on athletic injuries held in five locations in the state. The programs were arranged by the Division. It also cooperated in program planning for the College Health Instructors Institute held in Madison March 22–24, 1962. The purpose was to bring the key health instructors from Wisconsin's universities and colleges up to date on health information.

Health Examinations

A revised Health Examination Form was devised with the cooperation of the Division and is now being tested in three Wisconsin schools. The aim of the revision was to shorten and simplify the form to include only information of value to the school in serving the health and well-being of the student.

Physical Fitness

The Division has worked closely with the State Department of Public Instruction in many areas, including that of physical fitness, and has given

its support to the President's Physical Fitness Program. The Division plans to circulate to each county medical society the recommendations of the AMA for support of physical fitness programs.

Medical Excuses

"Medical excuses" from participation in physical education courses pose a difficult problem for physicians and school administrators. The Division has discussed this matter at length in conference with representatives of the State Department of Public Instruction and the State Board of Health. It has been concluded that as a basic principle no student should be excused from physical education provided some facility for modified physical education is available to permit limited participation. Accordingly, it recommends that school administrators develop modified physical education programs to make this effective.

VISUAL AND HEARING DEFECTS

In light of the dual function of the Division on Visual and Hearing Defects, two subcommittees have been created within the Division, one dealing with visual problems and the other on ear, nose and throat.

While assignments will be made to these subcommittees in the areas of their respective interests, the Division will continue to function as a unit in coordinating the over-all program in visual and hearing defects.

The Division met with representatives of the Industrial Commission for review of methods for determination of the impairment of (1) the eye and (2) ear, nose, throat and related structures. The Industrial Commission at the present time utilizes the recommendations of the American Medical Association for determination of hearing impairment (*J. A. M. A.* August 19, 1961). The Commission and the Division's Subcommittee on Visual Problems will explore the advisability and practicability of utilizing the recommendations of the AMA for determination of visual impairment. Subsequent meetings will be held with representatives of the Industrial Commission along these lines.

The Division has been working closely with several state departments on matters concerning hearing rehabilitation and hearing testing programs in schools. It encourages physicians to make greater use of hearing evaluation centers which have been established at the University of Wisconsin, Madison; the University of Wisconsin, Milwaukee; Green Bay Curative Workship; and Milwaukee Children's Hospital as well as similar facilities in physicians' offices and clinics.

There appears to be increasing awareness by physicians of the excellent services offered by these well-equipped and managed hearing evaluation centers. The Division is pleased to direct attention to the fact that these facilities are under the direct supervision of medical personnel.

In reviewing the work of the Bureau for Handicapped Children of the Department of Public Instruction, the Division particularly recommends the Bureau's guide for nurses, parents and volunteers in the conduct of hearing conservation programs.

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RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the report of the Commission on State Departments. The Committee emphasized that the mobile unit screening programs for tuberculosis, hypertension and cardiac diseases are available only at the request of the county societies. Physicians in local county medical societies are urged to continue cooperation in this program of the State Board of Health. The Committee also made particular note of Doctor Fox's comments concerning his appreciation of the 99 physicians serving on various divisions of this Commission.

HOUSE OF DELEGATES ACTION—Adopted the report of the Commission on State Departments as recommended by the Reference Committee.

MARK YOUR CALENDAR—MAY 6–7–8–9

1963 ANNUAL MEETING

Milwaukee

REPORT OF EDITORIAL BOARD—1961–1962

V. S. Falk, M. D., Edgerton, Medical Editor

The Editorial Board has continued to work in in closest harmony with the Commission on Scientific Medicine in attempting to present the latest and most valuable scientific information to readers of the *Wisconsin Medical Journal.*

Special consideration has been given to papers presented at the 1961 Annual Meeting. Quality of content, interest, length, accuracy, clarity and adherence to Journal format are considered in review of papers for publication.

The Editorial Board encourages original papers, especially those submitted by Wisconsin physicians.

At the present time, papers have been approved to carry through the July issue, which means that the length of time between approval and publication has been considerably shortened.

For the first time, the Journal published a special issue in October, 1961. A festschrift honoring William D. Stovall, M. D. was presented. This issue has been widely recognized as a unique and valuable contribution to medicine.

Very recently R. S. Baldwin, M. D., Marshfield, who served as medical editor for 12 years, resigned because of personal commitments. The Council appointed V. S. Falk, M. D., Edgerton, as the new medical editor. He had formerly been the assistant medical editor. Doctor Baldwin was appointed consulting editor.

The Editorial Board recommends that a resolution be passed in tribute to Doctor Baldwin for his excellent and arduous efforts in behalf of the *Wisconsin Medical Journal.*

MEDICAL EDITOR
V. S. Falk, M.D., Edgerton
CONSULTING EDITOR
R. S. Baldwin, M.D., Marshfield
EDITORIAL DIRECTOR
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M. C. F. Lindert, M.D., Milwaukee
D. W. Ovitt, M.D., Milwaukee

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended acceptance of the report of the Editorial Board.

HOUSE OF DELEGATES ACTION—Accepted report of Editorial Board as recommended by the Reference Committee.

RESOLUTIONS—1961–1962

RESOLUTION NO. 1

Introduced By: Commission on State Departments

WHEREAS, Hypnosis is a medical aid to be used only by qualified medical and dental personnel when there are specific medical indications for its use which have been substantiated and delineated by physician examination and mental evaluation; and

WHEREAS, Hypnosis appears to be increasingly popular for entertainment purposes in school and public programs with audience volunteers being involved in its demonstration, including the use of post-hypnotic suggestion as a cure for nail-biting and similar habits; and

WHEREAS, The State Medical Society of Wisconsin through its Division on Nervous and Mental Diseases of the Commission on State Departments has undertaken active public educational efforts concerning hypnosis; and

WHEREAS, The American Medical Association officially condemns the use of hypnotism for entertainment purposes; now therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin appeal to the American Medical Association to assist in the control of the non-medical use of hypnosis by:

1. Providing an authoritative statement for the public which state and county medical societies could distribute in their own communities.
2. Undertaking special efforts with the National Education Association to explain the dangers of hypnotism for entertainment purposes in their joint and separate communications to physicians, teachers and school administrators.
3. Establishing appropriate medical advisory services to "booking" services for school assembly programs to assure accuracy and reliability on topics involving or affecting the health of school students and personnel; and be it further

Resolved, That the American Medical Association urge all state and county medical societies to cooperate in the educational effort outlined above.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of Resolution No. 1 with the elimination of item 3 in paragraph 5, since this Committee felt that it should more properly be a part of Resolution No. 3.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 1 as amended by the Reference Committee.

RESOLUTION NO. 2

Introduced By: Commission on State Departments

WHEREAS, Scientific investigation has shown that the use of seat belts will reduce the frequency and severity of any auto accident injury by at least 55 per cent, and reduce fatal injuries by as much as 35 per cent; and

WHEREAS, The State Medical Society of Wisconsin and the American Medical Association have been advocating their use since 1955; and

WHEREAS, The American Medical Association, the National Safety Council and the United States Public Health Service for two years have been making a joint effort to popularize the use of seat belts; and

WHEREAS, ALL American made cars beginning with 1962 models will have front seat belt anchorages as standard equipment; and

WHEREAS, Wisconsin became the first state in the nation to require installation of front seat belts in all 1962 and later model automobiles sold in the state; and

WHEREAS, Physicians are looked to by their patients for sound advice on matters of health and accident prevention; therefore be it

Resolved, That the State Medical Society of Wisconsin officially advocate the use of automobile seat belts and that the House of Delegates of the State Medical Society urge every physician in Wisconsin to use seat belts in his auto or autos, and that the members of the House, members of the Council and the officers of the State Medical Society of Wisconsin set the example by using seat belts in their own automobiles.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of Resolution No. 2.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 2 as recommended by the Reference Committee.

RESOLUTION NO. 3

Introduced By: Commission on State Departments

WHEREAS, Recent experiences with hypnosis for entertainment purposes in Wisconsin indicate the ease with which unsound and even dangerous health practices may honestly and unwittingly be accepted into school health programs; and

WHEREAS, Similar opportunities for misinformation and misunderstanding are present in many other important aspects of school health such as physical examination and periodic checkups, athletic safety, mental health, communicable disease control, physical fitness, health education and the use of qualified health personnel; and

WHEREAS, A major objective of school health programs is the creation of an atmosphere of confidence and understanding of sound medical procedures and the establishment of favorable attitudes toward individual responsibility for one's own health; now therefore be it

Resolved, That the House of Delegates of the State Medical Society suggest to the Amercian Medical Association that it has unparalleled opportunity to focus attention on the great issues of health education and practices affecting school age citizens through the development of a special school health issue of TODAY'S HEALTH, the nation's most authoritative monthly health magazine for the American family; and be it further

Resolved, That the House of Delegates of the State Medical Society is proud to pledge its support to assure the widest possible promotion and distribution of such a special issue of TODAY'S HEALTH to educators, school administrators and parents; and further urges that all state and county medical societies act in concert with the American Medical Association in such an endeavor.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of Resolution No. 3 as amended to include the insertion of the following:

> **"Resolved, That appropriate medical advisory services to booking services for school assembly programs to assure accuracy and reliability on topics involving or affecting the health of school students and personnel be provided; and be it finally"**

after paragraph 4 of the resolution.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 3 as amended by the Reference Committee.

RESOLUTION NO. 4

Introduced By: Commission on State Departments

WHEREAS, Public health officials report cases of infectious syphilis have tripled in the U. S since 1957, with an especially alarming increase among teenagers; and

WHEREAS, The Wisconsin State Health Officer reports 1,000 cases of syphilis including 21 deaths, and 1,267 cases of gonorrhea in the state in 1960, with little or no improvement in 1961, and he estimates that only one out of every four cases of gonorrhea is being reported in Wisconsin; and

WHEREAS, The most important element in venereal disease control is the tracing of sources and contacts from the diagnosed case, the latter point being the primary responsibility of the physician; and

WHEREAS, To preserve confidentiality of reporting in the many areas of the State which have nonmedical local health officers, the Wisconsin Statutes require reporting by physicians of *all* cases of venereal disease to the *State* Board of Health; therefore be it

Resolved, That the House of Delegates of the State Medical Society urge the State Board of Health to develop and distribute to the medical profession a simplified summary of the rules for reporting with indications of the newer methods of therapy and management; and be it further

Resolved, That the House of Delegates request that an appropriate committee of the Society work with the State Board of Health in the development of an effective informational program for the profession; and be it finally

Resolved, That when this information is made available, each county medical society and hospital medical staff be requested to officially bring the subject of venereal disease reporting before its members for discussion.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of Resolution No. 4 with an amendment to read as follows, replacing paragraph 6 of the resolution:

> **"Resolved, That the House of Delegates request that an appropriate committee of the Society work with the State Board of Health to analyze the incidence and source of venereal diseases in Wisconsin and to develop an effective informational program for the profession; and be it finally".**

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 4 as amended by the Reference Committee.

RESOLUTION NO. 5

Introduced By: Commission on State Departments

WHEREAS, The prevention and control of injuries in sports is a joint responsibility of parents, teachers, school administrators, athletic directors and coaches as well as physicians and dentists in the community; and

WHEREAS, The Division on School Health of the Commission on State Departments applauds and encourages the county medical societies and local physicians to cooperate in efforts to assure continuing medical supervision of high school athletes; and

WHEREAS, A growing number of high schools in Wisconsin now have a physician in attendance at games to provide emergency care; now therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin encourage component county societies and local physicians to participate in sports injury prevention and control programs in as many high schools as possible according to the basic standards suggested by the Joint Statement of the Committee on Injuries in Sports of the American Medical Association and the National Federation of State High School Athletic Associations and that local medical societies be encouraged to appoint interested physicians as team physicians; and be it further

Resolved, That physicians who serve as team physicians be encouraged to do so for a full season in a particular sport, or for a full school year, since this provides familiarity with the individual characteristics and medical background of each athletic participant; and be it further

Resolved, That a team physician be encouraged to attend all scheduled competitive events and that

school officials assure him a place on the bench, or in close proximity to it, so that he may more readily observe the occurrence of injury and provide aid more promptly.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of Resolution No. 5, with the added recommendation that physicians aid in the dissemination of information to school administration and school boards concerning more comprehensive insuring programs for students.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 5 as recommended by the Reference Committee.

RESOLUTION NO 6

Introduced By: Editorial Board

WHEREAS, The Editorial Board in recognition of the great contribution to scientific knowledge which R. S. Baldwin, M. D. has made to the physicians of Wisconsin in his capacity as Medical Editor of the *Wisconsin Medical Journal*; and

WHEREAS, During the 12 years of his tenure, there has been a significant increase in readership from the national level as well as the local level; and

WHEREAS, The quality of scientific information has been greatly improved under his guidance; therefore be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin commend R. S. Baldwin, M. D. for his devoted service to the *Wisconsin Medical Journal* and the members of the Society.

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Recommended adoption of Resolution No. 6.

HOUSE OF DELEGATES ACTION—Adopted Resolution No. 6 as recommended by the Reference Committee.

RESOLUTION NO. 7

Introduced By: Section on General Practice
Raymond R. Richards, M. D., Delegate
John A. Kelble, M. D., Alternate

WHEREAS, The Board of Trustees of the American Medical Association has clarified the ethical considerations related to physicians assisting other physicians in the performance of surgery; and

WHEREAS, The public pronouncements of those few who disagree with the judicious and reasonable statement of the AMA succeed only in creating confusion and attracting disdane for the entire profession; now therefore be it

Resolved, That the State Medical Society of Wisconsin commend the AMA for its forthright statement of ethical principles; and be it further

Resolved, That all specialty organizations in Wisconsin be urged to attempt solutions of ethical and economic problems affecting all doctors through proper medical channels.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Since this resolution pleads that all segments of the State Medical Society of Wisconsin should attempt solution of ethical and economic problems through proper medical channels, and since Chapter VI, Section 3 of the Bylaws states that "all questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion", the Committee recommended that Resolution No. 7 be referred to the Council as directed.

MEDICAL ART SALON REVEALS MUCH TALENT AMONG S.M.S. MEMBERS AND AUXILIARY

The first Medical Art Salon, staged at the State Medical Society annual meeting in Milwaukee in May, drew 58 entries in oil paintings and watercolors done by state doctors and their wives, and it continues to draw words of praise and encouragement for a repeat performance.

Displayed on the stage of the Milwaukee Auditorium, the showing was hung by Taizo Miake of the Layton School of Art, Milwaukee, and judged by Edward Dwight, director of the Memorial Art Center, Milwaukee.

Awards in oil painting went to Mrs. Marvin Wells, Milwaukee, first, for "Teton E. C. G."; Dr. William Hovis, Milwaukee, second, for "Matador"; Mrs. Edward B. Jacobson, Milwaukee, third, "Red Lights"; and Mrs. Stanley Berlow, Milwaukee, "Street Scene", and Dr. John Erbes, Milwaukee, "Grey Barn", both honorable mention.

In watercolor, the first award went to Dr. Carl Chelius, South Milwaukee, for his "Old Milwaukee". Second, third and two honorable mention awards were as follows: Dr. G. E. Gutmann, Janesville, "Sailing"; Dr. Maurice Hardgrove, Milwaukee, "Jones Island"; Mrs. Paul Odland, Janesville, "Still Life"; and Dr. M. M. Baumgartner, Janesville, "Fishing."

Doctor Erbes won the most popular painting award for his "Grey Barn." Mrs. J. Howard Johnson, immediate past president of the Woman's Auxiliary, is credited with the idea for the art exhibit, and many doctors and their wives have expressed a desire to submit entries next year.

HOUSE OF DELEGATES ACTION—Referred Resolution No. 7 to the Council as recommended by the Reference Committee.

RESOLUTION NO. 8

Introduced By: Brown County Medical Society

WHEREAS, The danger of governmental regimentation of medical practice is ever present and must watchfully be guarded against; and

WHEREAS, Insurers of medical care have shown evidences of infringing upon the doctor—patient relationship by gradual progression; and

WHEREAS, There have been indications that some leaders of organized society have been working toward prepaid medical care insurance plans of an inflexible form, with compulsory participation of the physicians; now therefore be it

Resolved, That we as practicing physicians in the State of Wisconsin shall retain the integrity of the doctor-patient relationship as affecting both treatment and financial transactions; and be it further

Resolved, That there shall be no interference in this relationship by insuring agencies or by agencies of the various medical societies except as agreed to in writing by the individual physician.

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Since means of resolving this problem are available under already existing administrative procedures, the Committee recommended that Resolution No. 8 be not accepted.

HOUSE OF DELEGATES ACTION—Resolution No. 8 was not accepted as recommended by the Reference Committee.

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REPORT OF COMMITTEE ON DISASTER MEDICAL CARE—1961–1962

J. S. Wier, M. D., Fond du Lac, Chairman

A program to teach at least one member of each American family how to survive a national emergency and how to meet their own health needs if deprived of a physician's services has been developed by the United States Public Health Service in cooperation with the American Medical Association. This program is entitled Medical Self-Help Training.

In a letter directed to the State Medical Society of Wisconsin, the American Medical Association requests the support and active participation of Wisconsin physicians in this program:

> "Members of the medical profession have an opportunity to make a significant contribution to strengthening our civil defense capabilities by supporting this program and offering all possible cooperation in its conduct. The AMA believes that every physician has a solemn duty and obligation to assist in preparing the public for civil defense readiness."

On February 24, 1962, the Council of the State Medical Society, acting on the recommendation of the Committee on Disaster Medical Care, endorsed the Medical Self-Help Training Program for Wisconsin and requested the support and cooperation of all county medical societies and the membership in its implementation.

Medical Self-Help Training is outlined in detail in Public Health Service Publication No. 858 (available on request to the Society), and in Wisconsin, the program is already under way.

Representatives of the State Bureau of Civil Defense, State Board of Health, State Medical Society and State Department of Public Instruction form the Executive Committee which advises the Bureau of Civil Defense on the conduct of the program in this state. The State Board of Vocational and Adult Education and the University of Wisconsin Cooperative Agriculture Extension Service serve as participating agencies. The State Board of Health will administer the program.

For its part, the State Medical Society agrees to provide support and professional medical advice to the State Board of Health in administering the program; encourage county medical societies, county civil defense medical directors and individual physicians to provide guidance, professional leadership and participation as instructors for locally presented courses; and to actively promote the program.

Courses are currently being initiated in 75 areas of the state. Training kits have been allocated to selected vocational schools, county home demonstration agents, county civil defense directors and local full-time city and county health departments. They, in turn, will arrange the conduct of local instructional courses. Organizations and groups interested in taking the eight 2-hour training sessions should contact these agencies.

The attention of all county medical societies is directed to the following statement of policy with regard to Medical Self-Help Training, in which the committee concurs:

> ". . . The practicing physician . . . will be asked to provide the professional leadership so necessary for the successful teaching of the general population. To assist him and to do the actual instruction in most cases, the wholehearted support of the allied health worker and individuals with previous experience in this type of teaching is necessary.
>
> "Whenever possible, however, it is highly desirable that each course be taught under the supervision and guidance of the physician if other than a physician serves as an instructor."

Since this is not first aid, but medical self-help, it is extremely important that the medical profession accept this responsibility in each community.

In other areas of disaster preparation, the Committee continues to work closely with the State Board of Health, State Bureau of Civil Defense and other agencies. The Committee has learned that a number of counties in the state are not at present effectively organized to carry out certain necessary activities in civil defense. Among these is the organization of medical services in civil defense. Although civil defense is primarily a responsibility of the civil government, the Committee points out that if no action is forthcoming from that source, and some emergency arises, the medical profession might find itself taking the brunt of public antagonism at lack of preparation for meeting medical emergencies. The Committee therefore urges each county medical society in areas where no county civil defense medical director has been named to make a strong appeal to the county board for early action.

The Committee on Disaster Medical Care of the American Medical Association has recently sought an opportunity to have one of its members and an AMA staff member meet with our state Committee. The purpose of this meeting would be to obtain detailed information on this state's activities in the

field of medical preparedness for disaster. The Committee will be most pleased to host the AMA representatives at its next meeting.

COMMITTEE ON DISASTER MEDICAL CARE
J. S. Wier, M.D., Fond du Lac, Chairman
E. A. Bachhuber, M.D., Milwaukee
S. J. Graiewski, M.D., Oshkosh
D. L. Williams, M.D., Madison
Harold Cook, M.D., Milwaukee
E. P. Rohde, M.D., Galesville

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Endorsed the statement of policy with regard to Medical Self-Help Training embodied in the report and recommended acceptance of the report of the Committee on Disaster Medical Care. The Committee also recommended that members of county medical societies offer their services to the local civil defense director for the program outlined in the Guide published by the U. S. Public Health Service. There are 80 teaching kits available in the State, and local physicians should be informed of their whereabouts.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Disaster Medical Care as recommended by the Reference Committee with the additional recommendation.

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REPORT OF THE COMMITTEE ON MILITARY MEDICAL SERVICE—1961–1962

F. L. Weston, M. D., Madison, Chairman

In a repeat of earlier "Doctor Draft" activities, Selective Service was called upon, starting last August, to deliver large numbers of physicians for the Armed Forces.

Selective Service in Wisconsin received three special calls for physicians during this period. These involved physicians age 27 and under, and calls were made upon the youngest first. As a result, a total of 27 Wisconsin physician registrants called through the Selective Service mechanisms are now on active duty, commissioned and awaiting duty, or in process of commissioning.

This, however, does not reflect the entire picture. The Committee on Military Medical Service, acting to assist the Wisconsin State Advisory Committee to Selective Service, provided recommendations of availability or essentiality on 56 physicians. The appreciation of the Committee goes to Councilors and Officers and others who assisted in these determinations.

Several problems which were new, or more severe than in previous calls, were encountered during this activity. The calls were not distributed evenly upon the medical population, nor could they be as they were based on age. As a consequence, the impact fell most heavily on a limited age bracket, and many of these were in residency training. It happened also that these calls coincided with the recall of the 32nd Infantry Division which removed another 12 physicians from practice in Wisconsin.

It seems important to point out once again that physicians who are in training beyond the intern level are subject to Selective Service call unless they have completed their active military requirements or are proceeding under the Armed Services Residency (Berry) Program or under the Public Health Service Residency (Cord) Program. It is a basic policy nationally, as well as locally, that physicians shall not be deferred solely for the purpose of permitting them to complete their residency training program.

As a practical matter, deferment of residents can be granted only if it can be established that a resident's services are absolutely essential to the hospital. Each case must be individually considered. This Committee will continue to evaluate each community and each hospital situation on its own merits with a view to striking a reasonable balance between the needs of the Armed Forces and the health needs of Wisconsin.

It is axiomatic that the needs of the Armed Forces for physicians, if not filled by voluntary commissioning, will be filled through Selective Service. When such calls are made, the physicians are needed at that time, not after they have completed their residencies or a specific year of their training. Undoubtedly some improvement could be made in national planning, and the Committee is considering suggestions to be made in this area.

It is evident that no predictions can be made concerning future calls of physicians through Selective Service. It is equally apparent that the Society should stand ready at all times to move rapidly and effectively in the event that Selective Service calls are re-instituted. With the concurrence of the Council, the Committee is prepared to maintain its mechanisms for carrying out this function.

In conclusion, the Committee is pleased to report that it has had the utmost in cooperation from Wisconsin Selective Service Headquarters, and expresses its sincere appreciation.

COMMITTEE ON MILITARY MEDICAL SERVICE
F. L. Weston, M.D., Madison, Chairman
J. M. Sullivan, M.D., Milwaukee
M. H. Steen, M.D., Oshkosh
O. G. Moland, M.D., Augusta
D. S. Arvold, M.D., Shawano

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended acceptance of the report and commended the Committee on Military Medical Service for its efforts in attempting to minimize the problems of patient care and residency training throughout the State resulting from increased demands by Selective Service. The calling to active service of the 32nd Division placed an unusually heavy burden on this State to fulfill the needs of the armed forces for physicians. The Reference Committee expressed its pleasure with the cooperation that the Committee on Military Medical Service had received from the Selective Service headquarters.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Military Medical Service as recommended by the Reference Committee.

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REPORT OF COMMISSION ON SCIENTIFIC MEDICINE—1961–1962

R. B. Larsen, M. D., Wausau, Chairman

The Commission on Scientific Medicine is primarily concerned with the preparation of teaching programs for the members of the State Medical Society of Wisconsin. This past year major emphasis has been placed on the preparation of an Annual Meeting program which will be of value to members of the various specialties, as well as for those in general practice. The Commission has enjoyed the finest of cooperation from all groups in the preparation of a program which it is felt will be of real interest to the majority of our members. We are also pleased to report splendid cooperation from various medical staffs of Wisconsin hospitals in the preparation of outstanding scientific exhibits.

The Commission is pleased with the action of the Council to move the meetings of the House of

REFERENCE COMMITTEE ON STANDING COMMITTEES. Drs. J. E. Martin, Jr., Delavan, F. E. Gehin, Stevens Point, chairman; W. T. Russell, Sun Prairie; G. W. Hilliard, Milwaukee; and H. G. E. Mallow, Fort Atkinson.

Delegates and the Reference Committees to the Milwaukee Auditorium. We hope this shift in location will be satisfactory to the delegates and others who attend the business meetings of the House of Delegates, so that those members can more readily attend scientific programs when they are not directly concerned with functions of the House.

Shift in Emphasis in Teaching Programs

This past year 10 meetings of a regional nature were presented as part of the "Circuit Teaching Programs." While successful in terms of value to those in attendance, it is apparent that with more county society meetings devoted to scientific matters, supported through the Speakers Service, and an expanding program of postgraduate medical education presented under the auspices of the Wisconsin Academy of General Practice, there is no longer as great a need for this type of instruction as was the case shortly after World War II. Because of this, the Commission intends to restrict these programs during the ensuing year to one or two circuits in the northern part of the state, during the Fall months.

Special Conferences

During the past year major emphasis has been placed on conferences of physicians and hospital personnel in areas of newborn care, prematurity care, the continuing programs associated with the Maternal Mortality Survey, and a statewide conference on "Medical Aspects of Mental Retardation."

Problems of the Newborn: Two conferences in this area were presented with a total attendance of 306 persons (138 M. D.s, 151 nurses from hospitals, and 17 miscellaneous . . . nurses not associated with hospitals, medical students and State Medical Society staff). These conferences were held in Wausau and Green Bay, with the regional units of the Wisconsin Academy of General Practice and the Bureau of Maternal and Child Health of the Wisconsin State Board of Health as joint sponsors, with the Division on Maternal and Child Welfare of the State Medical Society.

Prematurity Institutes: A total of seven regional institutes in this area have been presented, with the State Medical Society and the Wisconsin State Board of Health as joint sponsors. Meetings have been held in Viroqua, Sheboygan, Milwaukee, Appleton, Dodgeville, Park Falls and Rice Lake. Several hundred physicians and an equal number of hospital nurses and supervisors have attended these meetings.

Maternal Mortality Institutes: Two interpretative programs have been held since May of 1961: One in Wausau on May 24, in cooperation with the Wisconsin Valley Chapter of the Wisconsin Academy of General Practice, and a second meeting in Madison on February 15, with the Madison Chapter of the Academy as joint sponsor. More than 200 persons have attended these conferences, with the majority being physicians, as the teaching program is primarily directed to them. The Madison meeting was in the nature of a "working conference" with actual case studies reviewed and evaluated by all those present, with attendance controlled as to hospital participation.

Mental Retardation: Last June a statewide conference on "Medical Aspects of Mental Retardation" was presented in Milwaukee, in cooperation with the Wisconsin Council for Mentally Retarded Children, Inc. A total of 108 physicians and 76 nonmedical personnel attended the conference, and the concensus of those in attendance was that the meeting had value and might well serve as the basis for a series of regional conferences, bringing the subject down to the local level and directed primarily to the family physician of children presenting this special problem to the family and the home.

Medical Aspects of Sports

The Council of the State Medical Society at its July, 1961 meeting expressed an active interest and concern in this subject and pledged its cooperation in aiding the Commission to establish a continuing program for physicians involved in the care of students through the twelfth grade. A warm reception was given us by the Executive Secretary and Board of Control of the Wisconsin Interscholastic Athletic Association, and this year at the Annual Meeting we have the initial in a series of programs designed for physicians and stressing particularly athletic injuries. The Commission has cooperated in establishing programs jointly with the W. I. A. A. for the Coaching Clinics and the Summer Session.

The public relation benefits of all these programs are beyond calculation, and give evidence that the physicians of Wisconsin are continually improving their own knowledge in the areas covered by the

conferences, and at the same time are eager to share their knowledge with nurses and parents, most directly concerned with hospital or home care of the patients involved. The Wisconsin press has carried many stories on these teaching programs. The Commission feels that these special conferences have been of tremendous value to the membership, both in terms of specific knowledge acquired through attendance and to the entire Society in terms of interprofessional and public relations.

Speaker Service to County Societies

The Commission is pleased to report that a number of county medical societies have availed themselves of speakers furnished through the Speakers Service of the Charitable, Educational and Scientific Foundation. This program, financed by a generous donation from the Postgraduate Medical Program of Merck Sharp & Dohme Co., with supporting funds from the State Board of Health, the Wisconsin Heart Association, American Cancer Society (Wisconsin Division), and Wisconsin Anti-Tuberculosis Association has provided 44 speakers to 19 county medical societies from September 1, 1961 through March 1, 1962 (additional speaking engagements are scheduled for March, but are not included in this report).

With the continued support of agencies indicated, it is hoped that this program can be carried on for the ensuing year.

Summary of Physician Education

The past eleven months of postgraduate activity on the part of the State Medical Society reached a total of 1,616 physicians in almost every county of the state. In addition there was a total non-medical attendance by 574 persons, making total attendance for these programs 2,190.

Programs presented through the Speakers Service reached 958 physicians. The special teaching conferences on maternal mortality, problems of the newborn and mental retardation were attended by 318 M. D.s and 368 non-medical persons. The circuit teaching programs reached 241 physicians and the prematurity institutes were attended by 99 M. D.s and 206 non-medical persons.

This is an impressive record on the part of Wisconsin physicians by way of attendance at Society-sponsored postgraduate programs. It represents a significant investment in time, personnel and funds which have been made through the support of the Society, the Charitable, Educational and Scientific Foundation and important donations from various sources. We believe the results speak for themselves.

COMMISSION ON SCIENTIFIC MEDICINE

R. B. Larsen, M.D., Wausau, Chairman
R. W. Farnsworth, M.D., Janesville
A. R. Curreri, M.D., Madison
P. T. Bland, M.D., Westby
G. E. Collentine, Jr., M.D., Milwaukee
V. S. Falk, M.D., Edgerton
P. P. Cohen, M.D., Madison
J. S. Hirschboeck, M.D., Milwaukee

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended acceptance of the report of the Commission on Scientific Medicine and commended the Commission members for an excellent job. The activity of this Commission, the Committee emphasized, is one of the major reasons for the existence of the State Medical Society, and it has had ambitious programs of postgraduate medical education to stimulate increasing interest by changing the emphasis from circuit teaching programs to special conferences as outlined in the report and continuation of the Speakers Service to county societies.

HOUSE OF DELEGATES ACTION—Adopted the Commission's report as recommended by the Reference Committee.

REPORT OF COMMITTEE ON GRIEVANCES 1961–1962

E. D. Sorensen, M. D., Elkhorn, Chairman

The committee's report follows the character of those of other years because reporting of individual matters considered through it and its mechanisms would serve little purpose. Actual meetings of the committee have been less numerous than in other years. Part of this arises out of increased activity of county medical societies in handling matters involving local public relations, and very possibly a part arises out of the fact that the committee and staff have learned better the various techniques of handling problem matters.

It seems to committee members, in many cases, that those presenting problems to us wish the opportunity of independent advice and feel they can better secure that outside the community in which they reside than in it. But these are very minimal considering the tremendous volume of patient visits in the course of a year, and the committee is satisfied that the situation in our state between patient and physician is a very satisfactory one on the whole. In some few cases it seems apparent that physicians' charges, while reasonable, were not anticipated by the patient. The committee reminds physicians that they should take care that the patient is adequately informed. The following AMA-produced assurance to patients, which can be secured through the state office at nominal expense, could well be used by all physicians:

TO ALL MY PATIENTS:

I invite you to discuss frankly with me any questions regarding my service or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient.

On the whole, however, we are satisfied that increased attention to public education as to costs of specific health care and the programs of the past few years directed at the physician's responsibility in this respect have produced measurable results. Your committee will remain active.

COMMITTEE ON GRIEVANCES

E. D. Sorenson, M.D., Elkhorn, Chairman
E. W. Mason, M.D., Milwaukee
R. W. Mason, M.D., Marshfield
R. E. Fitzgerald, M.D., Milwaukee
K. A. Morris, M.D., Merrill
J. D. Leahy, M.D., Park Falls
H. J. Belson, M.D., Manitowoc
R. R. Richards, M.D., Eau Claire
T. J. Nereim, M.D., Madison

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended acceptance of the report of the Committee on Grievances and endorsed the suggestion of the Grievance Committee that physicians use the AMA plaque.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Grievances as recommended by the Reference Committee.

One inch of joy surmounts of grief a span, because to laugh is proper to the man, wrote Rabelais some 400 years ago. A merry heart doeth good like a medicine, says Proverbs 17:22.

REPORT OF COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION 1961–1962

R. S. Gearhart, M. D., Madison, Chairman

Hospital Achievement Award

Prior to the opening session of the Annual Meeting of the State Medical Society in May 1961, upon recommendation of the Commission, the Council made the Community Achievement Award of the State Medical Society of Wisconsin to St. Joseph's Hospital, Hillsboro, and to St. Luke's Hospital, Racine. Dr. James C. Fox, Chairman of the Council, made the presentation of the Community Achievement Award to St. Joseph's Memorial Hospital on May 7, 1961. Dr. L. H. Lokvam, President of the State Medical Society, presented the Community Achievement Award to St. Luke's Memorial Hospital, Racine, on May 11, 1961.

The Commission has proceeded with the Community Achievement Award Program for 1962 by contacting presidents and secretaries of county medical societies inviting them to submit a statement recommending a familiar hospital for this Award setting forth reasons why it is believed the recommended hospital is deserving of such recognition.

The Community Achievement Award is presented to the hospital "whose facilities, personnel and medical staff have been so combined with the spirit of service and the art of helping as to present an outstanding example of how the medical profession and the hospital working together provide superior patient care and public service in the fulfillment of the American tradition."

Medical Education

Following its initial studies in the field of postgraduate medical education, begun in 1961, the Commission sponsored a Conference on Internship Programs held at the Society headquarters on Saturday, May 20, 1961. The program was moderated by R. S. Gearhart, M. D., Chairman of the Commission. Presentations were made by Leland S. McKittrick, M. D., Boston, Mass., Chairman, Council on Medical Education and Hospitals, American Medical Association; James Campbell, M. D., Chicago, Illinois, Board of Directors, National Intern Matching Program; Richard Saunders, Jr., M. D., New York City, Associate Dean, Cornell University Medical College; Mr. George E. Cartmill, Jr., Detroit, Michigan, Director, Harper Hospital.

The presentations were discussed by R. S. Gearhart, M. D., Madison; Robert W. Burn, M. D., Milwaukee; R. E. McMahon, M. D., La Crosse; Mr. Warren R. Von Ehren, Madison. Following the formal part of the program there was considerable discussion and questions on the part of those in attendance.

Twenty-one hospitals of Wisconsin were represented and the attendance at the meeting numbered 73 persons, not including participants on the program.

It is planned that in a future issue of the *Wisconsin Medical Journal* the four papers which composed the formal part of the program will be published.

Need for Medical Students

The Commission has continued its consideration of the dwindling supply of applicants, in both quantity and quality, to the two medical schools in Wisconsin. Members of the ad hoc Committee on Medical Education addressed graduating high school seniors in June of 1961 in two Wisconsin high schools setting forth the program of medical education and the need for physicians. Follow-up contacts were made with the registrars of the University of Wisconsin and Marquette University to determine the success of this program.

Of the 56 students who entered university programs, 28 are enrolled in a general course leading to a B. A. or B. S. degree. One is enrolled in dentistry, one in dental hygiene. While it is too early in the student's curriculum to determine his choice of profession, it is possible that some of the 28 referred to above will enter medical school.

The Commission, in its endeavor to increase the enrollment of students in schools of medicine, believes the county medical societies can assist greatly in this objective. Each county medical society will be requested to assist the Commission in its endeavor and if possible to appoint a member of its society to act as the medical school recruitment officer for the society.

Recruiting pamphlets and literature are available from the State Medical Society, American Medical Association, University of Wisconsin Medical School and Marquette University School of Medicine. It is hoped county medical societies will encourage graduating high school students to consider medicine by making available to them literature, pamphlets and further facts on medicine as a career, by participating in career days held at high schools and other counseling efforts.

Liaison with the Nursing Profession

The Executive Committee of the Council requested that the Commission meet with representatives of the Wisconsin State Nurses Association and the Department of Nursing to develop closer liaison and better relationships between nurses and physicians.

During the initial meeting one area for beginning discussions was the matter of delegation by the physician of certain acts, procedures and duties to the professional nurse. Closely associated with delegation of any type is the question of education and competency of the person to whom the act or action is being delegated.

It was agreed the initial meeting of these two groups was beneficial to each, and continuing liaison through subsequent meetings is planned.

Special Recommendation

The Commission considered the Duval (Florida) County Medical Society Resolution, copy of which accompanies this report. (See following page)

The Commission is opposed to the resolution as presented and instructed its Chairman to report to the Council its recommendation that "only reports of clinical laboratory work done in laboratories supervised by qualified pathologists should be accepted for hospital in-patients or out-patients. This should be the original report from the laboratory, properly authenticated, and placed in the patient's record."

This statement is made with the request that it be considered as an informal report from the Commission.

Chapter 484, Laws of Wisconsin, 1959

The Commission continues to receive numerous inquiries from physicians requesting specific case interpretations of Chapter 484 which relates to fee splitting between physicians and others. Such inquiries are considered by the Commission, and legal counsel, in some instances, is utilized to assist the Commission in arriving at a conclusion and submitting advice to the inquirer. To assist the

DUVAL (FLORIDA) COUNTY MEDICAL SOCIETY RESOLUTION

WHEREAS, Fear exists that accreditation be withdrawn from certain Jacksonville hospitals unless all recommendations of the Joint Commission on Accreditation of Hospitals are fulfilled, and

WHEREAS, Laboratory work should be considered a part of the practice of medicine, and

WHEREAS, Competent Doctors of Medicine other than qualified clinical pathologists can do laboratory work and can adequately supervise the work of technicians, and

WHEREAS, Duplication of laboratory work by hospitals unnecessarily increases the cost of medical care which is already high, and

WHEREAS, The assignment of patients to hospital laboratories as out-patients for laboratory work may entail long periods of waiting and increased anxiety, and

WHEREAS., The members of the Duval County Medical Society commend the purposes and principles usually proposed by the Joint Commission on Accreditation of Hospitals, but disagree strongly with this particular infringement on the practice of medicine,

Be it therefore resolved, That the Duval County Medical Society go on record in opposition to the recommendation of the Joint Commission on Accreditation of Hospitals to the effect that: "only reports of clinical laboratory work done in laboratories supervised by qualified clinical pathologists should be accepted for hospital in-patients or out-patients. This should be the original report from the laboratory, and properly authenticated, be placed in the patient's record."

Be it further resolved, that laboratory work attached to the clinical record by the responsible staff doctor be accepted at its face value, and

Be it further resolved, that safeguards be established and enforced against violations of the ethics and principles of this privilege, and

Be it further resolved, that the Joint Commission on Accreditation of Hospitals be informed of these recommendations and be requested to stop this trend toward the removal of authority for the patient's care from individual doctors of medicine who have not infringed upon privileges granted them, and

Be it further resolved, that a copy of this resolution be sent to the Florida Medical Association with the request that it adopt similar action and instruct its delegates to the American Medical Association to seek the adoption of like action by that body, and

Be it further resolved, that copies of this resolution be sent to each state medical association and to each county medical society in the state of Florida, and that they be urged to take similar action to safeguard the practice of medicine by doctors of medicine.

members of the Society, and others, in establishing standards under the Wisconsin Statutes, *Some Major Considerations Involved in the Guide to Interpretation of Chapter 484* was published in in 1962 Blue Book (January) issue of the *Wisconsin Medical Journal.*

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION

R. S. Gearhart, M.D., Madison, Chairman
T. H. McDonell, M.D., Waukesha
M. V. Overman, M.D., Neillsville
S. L. Henke, M.D., Eau Claire
T. E. Boston, M.D., Hillsboro
H. G. Bayley, M.D., Beaver Dam
C. J. Picard, M.D., Superior
G. B. Murphy, Jr., M.D., La Crosse
Edgar End, M.D., Wauwatosa
Philip P. Cohen, M.D., Madison, ex officio
John S. Hirschboeck, M.D., Milwaukee, ex officio

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended acceptance of the report of the Commission on Hospital Relations and Medical Education and commended the Commission for its program to encourage high school students to consider the medical sciences for their vocation. The Committee urged county medical societies to cooperate with the Commission in encouraging graduating high school students to consider medicine by making available to them the pamphlets and literature which are available from the State Medical Society, the American Medical Association, and the two Wisconsin medical schools.

Inasmuch as the portion of the Commission's report concerning the Duval County, Florida, resolution was presented as informal, and since another resolution on matters relating to pathology had been submitted in the supplementary report of the Council, no action was recommended on that portion of the report of the Commission.

HOUSE OF DELEGATES ACTION—Adopted the portion of the report of the Commission on Hospital Relations and Medical Education as recommended by the Reference Committee.

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REPORT OF COMMITTEE ON CANCER 1961–1962

Paul M. Cunningham, M. D., Appleton, Chairman

Cancer is now the second leading cause of death in Wisconsin. In 1960, the latest year for which complete reports are available, there were 6,156 Wisconsin deaths attributed to cancer. Of these, 3,219 were in males, 2,937 in females.

These statistics are but the "top of the iceberg," reminding the profession still again of the continuing responsibilities it has for cancer education, research and prevention.

Against this brief background of statistics the Committee on Cancer has developed its activities for the past year.

The Committee has taken the lead in developing regular meetings of representatives of the agencies and organizations—professional, public and private—concerned with cancer control in Wisconsin. For the first time in several years, some 15 groups meet periodically as a Cancer Coordinating Committee to discuss mutual problems and objectives. This is producing a worth while review of what is being done in the state for the control of cancer. It is also producing a more common understanding of needs in certain areas of professional and public education. These discussions will continue and during the next year it is anticipated the Coordinating Committee will prepare a number of recommendations concerning cancer detection, treatment and education.

Members of the Committee on Cancer and the Cancer Coordinating Committee have volunteered to prepare short, practical articles for the *Wisconsin Medical Journal* on such topics as colostomy care, Papanicolaou smears, enzyme studies and many other scientific subjects of interest to the physician concerned with detection and treatment.

The Committee was represented at the Annual Cancer Registry Workshop of the American College of Surgeons at Detroit. Later, the Committee plans to consider the potential value of a statewide tumor registry and methods to encourage locally established tumor registries.

In a number of sessions, the Committee has considered reports concerning the effects of smoking in relation to lung cancer. It is impressed with the evidence indicating that smoking is a major con-

tributory factor to increasing incidence of lung cancer. As a result it recommends that the State Medical Society, through its membership, give full support to the excellent smoking-lung cancer program being sponsored by the American Cancer Society in Wisconsin. This program is designed to acquaint young people with the dangers of smoking in relation to lung cancer. Physicians are urged to take part in presentation of programs by local units of the Cancer Society and to encourage attendance by their younger patients.

Cytology practices and facilities throughout Wisconsin are being reviewed by the Committee. Physicians are urged to continue and expand their use of this technique of cancer detection and to utilize their local laboratories where they are available.

COMMITTEE ON CANCER

Paul M. Cunningham, M.D., Appleton, Chairman
R. C. Frank, M.D., Eau Claire
G. I. Uhrich, M.D., La Crosse
R. C. Glise, M.D., Richland Center
G. A. Smiley, M.D., Delavan
J. J. Gramling, Jr., M.D., Milwaukee
J. F. Brown, M.D., Rhinelander
J. R. Hoon, M.D., Sheboygan
Robert S. Monk, M.D., Waukesha
R. R. Mataczynski, M.D., Superior
J. W. Boren, Jr., M.D., Marinette
M. W. Stuessy, M.D., Brodhead
G. H. Williams, M.D., Marshfield

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended acceptance of the report of the Committee on Cancer and commended the Committee on its anti-smoking program, especially in the teen-age group. The Committee further urged physicians to continue and expand their use of the cytology practices and facilities of cancer detection and to utilize their local laboratories where they are available.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Cancer as recommended by the Reference Committee.

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REPORT OF COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS—1961–1962

D. E. Dorchester, M. D., Sturgeon Bay, Chairman

Under the general direction of the Commission on Public Relations and Communications, the Society carries out a wide variety of public information activities designed to assist the profession in its relationships with the public, to obtain public reaction to matters of health education and to communicate sound health information to the public.

A brief factual summary will indicate the scope of these efforts during the past year:

. . . Fifty-two 15 minute radio programs on the "March of Medicine" were presented by 52 radio stations as a public service. Five years ago only 39 stations carried this program. The total audience is estimated at 350,000 persons per week.

. . . Inquiries from "March of Medicine" listeners reached a total of more than 1,100. These are personal letters which receive individual attention from the "March of Medicine" Medical Director, H. Kent Tenney, M. D., Madison.

. . . In addition, the Society received more than 2,000 requests for copies of "March of Medicine" programs.

. . . Ten of the "Best of the March of Medicine" programs are made available as tape recordings to high schools wishing to use them for classroom teaching. Last year 60 high schools used nearly 500 of these tapes.

. . . Five special radio interviews were arranged for broadcast over the state radio station network. All participants were physician members of the Society's divisions or committees.

. . . 45 film bookings were arranged for physicians, civic organizations and other groups.

. . . Two county medical societies were assisted in developing locally produced television programs.

. . . One county society was assisted in presenting a medical-press conference.

. . . 40 one-year subscriptions to "Today's Health" were awarded to 4-H Clubs who conducted outstanding health projects.

. . . 24 articles were written for the "Wisconsin Agriculturist" which reaches nearly 190,000 farm families in the state.

. . . 80 loan packets were supplied to high school and college students on medical and socio-economic subjects.

. . . 300 requests from physicians were handled to provide loan packets, medical society guides and literature on a variety of subjects.

. . . 85 news releases were issued to daily or weekly newspapers, wire services, radio and TV stations, and numerous requests were filled for media personnel.

. . . 1,500 students were provided with career material upon their request.

. . . 10,000 copies of health education literature were distributed to 4–H club members, homemakers and others.

. . . 26 lectures were arranged for student nurses and civic clubs on the subject of quackery and advice was provided to arrange many others in communities throughout Wisconsin.

The Commission is especially pleased to note the interest that is developing in the presentation of "health fairs" as a means of bringing medical progress and health education to the attention of the public. It recommends that all county societies take note of the Dane County Medical Society Health Fair to be held at the U. W. Camp Randall Memorial Building on May 23–27. The primary purpose of this event is to interest young people in careers in health. It is obvious, however, that its overall health education value has great potential. The Commission would urge county societies which might be considering such a project to arrange attendance at the Dane County Health Fair.

Representatives of the Commission will attend the AMA National Rural Health Conference in Des Moines on May 18–19. The Commission has plans also to meet in early June with representatives of the University of Wisconsin Agricultural Extension Service to discuss joint efforts in rural health programing. This will include representatives of Home Economics Extension and State 4–H Club Work.

Health work has always been a significant part of the Wisconsin Extension Service program. This has consisted of:

. . . Helping people study and analyze local situations and develop plans to solve problems in such areas as medical and dental personnel and facilities; immunization, physical examinations, early detection of cancer and heart disease, and care of degener-

ative ailments; sanitation, pure water supplies and general preventive health measures.
. . . Cooperating with health agencies and organizations to achieve improved health for rural people.
. . . Providing information to help rural people identify, understand and use available health services.
. . . Assist in organizing to obtain necessary services.
. . . Disseminating current health information from authoritative sources.

The State Medical Society and the State Board of Health have been major sources of assistance to the Extension Service in this activity. The Commission and the Extension Service believe that the time is ripe for review of the scope and status of extension education in the field of health in Wisconsin with an eye to setting new sights for joint activity.

At the same time, as a result of an American Farm Bureau Federation invitation to the American Medical Association to launch a cooperative program to improve rural health in America, the Commission plans conferences with the Wisconsin Farm Bureau Federation. The Farm Bureau envisions programs with emphasis on disease prevention, health of migrant workers and the aged, sanitation, nutrition, health careers, research and health insurance.

These encouraging developments in liaison with significant groups affecting the health of rural Wisconsin present a welcome challenge to the medical profession. The Commission expects that these conferences will produce substantial early progress and that specific recommendations may be prepared for Society action during the course of the year.

COMMISSION ON PUBLIC RELATIONS AND COMMUNICATIONS

D. E. Dorchester, M.D., Sturgeon Bay, Chairman
C. J. Picard, M.D., Superior
D. G. MacMillan, M.D., Barron
W. E. Acheson, M.D., Valders
J. E. Martin, Jr., M.D., Delavan
G. M. Shinners, M.D., Green Bay
J. S. Devitt, M.D., Milwaukee
Louis Olsman, M.D., Kenosha
C. A. Olson, M.D., Baldwin

RECOMMENDATION OF REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Recommended acceptance of the report of the Commission on Public Relations and Communications. Commended and praised H. Kent Tenney, M. D., for his untiring efforts in behalf of the "March of Medicine" program. Recommended that all county societies take note of the Dane County Medical Society Health Fair, held in Madison May 23–27, to interest young people in careers in health.

HOUSE OF DELEGATES ACTION—Adopted the report of the Commission on Public Relations and Communications as recommended by the Reference Committee.

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REPORT OF COMMISSSION ON MEDICAL CARE PLANS—1961–1962

E. M. Dessloch, M. D., Prairie du Chien, Chairman

While some reference is made here to activities other than those of the Society's own voluntary, prepaid medical care plan, the ever-better administration of Wisconsin Physicians Service was the foremost objective of the Commission on Medical Care Plans in 1961. All aspects of the Society's "insurance" operations will continue to be closely scrutinized in the year and years ahead.

It is recognized that much remains to be done: that not all objectives have been attained and that there are a number of areas in which results have fallen short of expectations, particularly in the all-important field of enrollment.

At the same time, it is a pleasure to report that by most statistical standards of measurement, Wisconsin Physicians Service made substantial progress in 1961.

Earned Premiums

Increased premiums do not necessarily suggest "growth" in terms of the numbers of subscribers served. On the contrary, premium growth is frequently attributable in considerable measure to rate increases, including those arising from the general "up-grading" of contract benefits. In addition any comparison of 1961 earned premiums with those of earlier years must recognize the entry of WPS into the hospital benefits field in 1958.

In 1957, the last full year during which WPS underwrote surgical-medical benefits only, its earned premiums were $5,308,167. For the reasons previously stated, the acceleration of earned premiums during the next four years was sufficiently rapid to far more than offset the loss of surgical-medical contracts to competition. This is borne out by the following earned premium figures:

1958	$5,802,177
1959	$7,687,512
1960	$9,164,209
1961	$9,707,643

Earned premiums of $9,707,643 in 1961 fell only about 3% short of a $10,000,000 premium objective. It is anticipated that 1962 earned premiums will be in the neighborhood of from $10,500,000 to $11,000,000.

Loss Ratios

The percentage relationship which claims incurred bear to earned premiums is most commonly known as "loss ratio." As expressed, the percentages represent the number of cents out of each earned premium dollar which are disbursed in the payment of contract benefits or which are set aside for claims received and not paid plus claims not reported but anticipated.

That there has been comparatively small variation in the *surgical-medical* loss ratios of the past five years is evident from the following:

1957	80%
1958	85%
1959	87%
1960	86%
1961	82%

The stabilization of the *hospital benefits loss ratio* during the past two years is reflected in these figures:

1958	87.35%
1959	99.23%
1960	88.77%
1961	84.85%

Health care claims payments (loss ratios) are, historically, higher during the first six months of the year than during the last six months. While there is no reason to believe that this pattern will vary in 1962, it is anticipated that underwriting results will again be favorable.

Expense Ratio

Administrative expense . . . the ratio of expenses incurred to premiums earned . . . was within the 12% objective. These figures show the extent to which these ratios have been reduced in each of the past five years:

1957	17.58%
1958	16.25%
1959	13.24%
1960	12.08%
1961	11.63%

While it is hoped that this trend will continue in 1962, increased funds have been budgeted for conducting an aggressive advertising and marketing program.

Investment Income

Investment and other income in 1961 totaled $114,720—an increase of $25,897 over the previous year. This growth is attributed to the addition of funds made available from operations and the implementation of an authorized investment program involving investment counsel, the treasurers, the Society's firm of certified public accountants, and the staff.

Basic changes in the portfolio of WPS investments resulted in improving the investment yield from 2.8% in 1960 to 3.4% in 1961, largely by converting from short-term to long-term government securities. Further diversification into commercial securities has been approved and will be undertaken as favorable market opportunities are presented.

Total Reserves

"Total reserves," frequently referred to as "surplus," is the amount by which assets exceed liabilities. The figure is in no way related to the reserves set aside for claims liability, unearned premiums, incurred but unpaid expenses or any other form of liability. It is accumulated solely in the interests of meeting unanticipated future financial contingencies should they arise.

The higher loss ratio on hospital premiums in 1958 and 1959 focused considerable attention on WPS "total reserves" as reported through March 31, 1960 and the May 1960 meeting of the House of Delegates. The forecast was made that rate adjustments and revisions in certain claims administration practices would witness an improvement in total operating results. That this prediction has materialized will be noted from the following comparison of total reserves for the periods indicated:

March 31, 1960	$1,007,292
June 30, 1960	$1,229,254
December 31, 1960	$1,454,938
June 30, 1961	$1,465,792
December 31, 1961	$2,016,752

The continued stabilization of the surgical-medical loss ratio and the sharp reduction in the hospital benefits loss ratio contributed heavily to this healthy financial result.

Contract Count

While "contract count" over the years from the end of 1957 to the close of 1961 has increased in *total* (surgical-medical, hospital, major illness), the active solicitation of health insurance by Surgical Care (The Blue Shield Plan of the Medical Society of Milwaukee County) throughout the state during that period accounts heavily if not solely for a sharp reduction in the WPS count of *surgical-medical* contracts.

As of December 31, 1957 the WPS contract count, almost entirely surgical-medical, stood at 143,697. Four years later there were in force 99,247 surgical-medical contracts, 43,954 hospital contracts and major illness contracts numbering 17,228—for a total of 160,429.

The extent to which competition, and the health insurance demands of the public have altered the complexion of our insurance operations is evident from a study of the foregoing figures.

Principal among our 1962 goals is that of increasing contract count (enrollment), and especially so the surgical-medical aspects of it. Supplementing the usual channels of acquiring and retaining business, WPS is accelerating its advertising activity, expanding its non-group agency facilities and entering the Milwaukee market.

Contract Retention

The retention of individual contracts and of small groups has continued at a satisfactory rate. By contrast, particularly as to one area of the state, the loss of a number of large groups to rate competition has made growth in contract count difficult.

At the same time, WPS has again been successful in renewing the surgical-medical coverage of its two largest prestige groups, State of Wisconsin Employees and General Motors of Janesville.

Claims Payments

Contract benefits paid by WPS since its inception in 1946 passed the fifty million dollar mark in 1961! The more exact figure through December 31, 1961 is $51,877,158.

With continuous counsel of its medical consultant, claims administration practices of WPS are under constant review. In 1961, WPS paid 91,692 bills submitted by physicians on behalf of subscribers, while 29,059 hospital bills were paid. With the acquisition of a larger number of major illness contracts, the volume of complex cases requiring processing has increased proportionately.

It is believed that the establishment of a utilization commission within the Council and of a utilization committee within the Commission on Medical Care Plans will assist the Commission materially in its direction of studies relating to the control of medical care costs.

Hospital Relations

During 1961 the administrator, hospital relations, attended 40 meetings in which matters pertinent to medical economics were discussed. The information secured through such attendance was transmitted to those best able to utilize it. In addition, he participated in all major coverage committee discussions, visited 71 physicians and called on 48 hospitals.

Contacts with physicians and clinics were, for the most part, in connection with problem cases which did not lend themselves well to handling by correspondence. Visits with hospital administration personnel were generally in response to specific requests for information and as a part of a continuing WPS public relations effort.

Service Improvement

As an added means of improving service to subscribers and increasing efficiency generally, a research division was established within the organization structure of WPS. Engaged essentially in fact-gathering and its evaluation, the centralization of this activity permits other departments to concentrate attention to matters relating to their special fields.

The preparation last fall of a guide to the advisory committees of county medical societies and the study of various health insurance markets are typical of the assignments undertaken by the research division.

In preparation for the late 1962 occupancy of the addition to the Society's headquarters, the position of office services director was created February 1 of this year. Responsibility for all so-called "service" functions will gradually be assumed by this division.

Added emphasis is being given to problems of procedures and work processing.

It is believed that the centralization of operations under one roof will lead not only to more efficient operation but to economies as well.

Special effort is being devoted to those systems which have greatest promise of reducing errors. While not all errors are detected and others are not quantitatively measurable, the reports of the internal auditor show marked improvement in this area.

Contract Review

Consideration of contract revisons was a major undertaking in 1961, not only as to the staff and consultants but as to the Commission on Medical Care Plans and its executive committee.

The Wisconsin Insurance Department, in exercising its statutory supervisory authority over the Blue plans, is in the process of examining their contract documents. While some WPS contracts have been revised and other re-drafts remain to be submitted, it is not anticipated that there will be any major changes in contract intent or in the administration of claims. This is one of the most time consuming assignments in which the staff and legal consultants will continue to be involved in 1962.

Medicare

The activation of Wisconsin's 32nd Division in late 1961 produced a sizeable increase in inquiries to both physicians and the Society regarding Medicare benefits.

A program which involved the processing of almost 6,000 claims and more than $400,000 in benefits necessitated the handling *each month* of over 700 pieces of correspondence and 200 telephone calls with physicians and the dependents of men in military service. It is small wonder that the future of government-sponsored health care programs are viewed by many with a jaundiced eye.

The 1962 renewal contract between the Society and the Federal Government has been executed. It includes requirements for additional statistical reporting on payments to physicians, with resultant increase in handling costs. While this and other like situations have been reported to the Office for Dependents' Medical Care, the reporting detail thus far remains unchanged.

COMMISSION ON MEDICAL CARE PLANS

E. M. Dessloch, M.D., Prairie du Chien, Chairman
H. A. Aageson, M.D., Oconto
E. L. Bernhart, M.D., Milwaukee
G. W. Carlson, M.D., Appleton
W. T. Casper, M.D., Milwaukee
M. D. Davis, M.D., Milton
K. H. Doege, M.D., Marshfield
Milton Finn, M.D., Superior
D. N. Goldstein, M.D., Kenosha
A. W. Hilker, M.D., Eau Claire
J. H. Houghton, M.D., Wisconsin Dells
Donald A. Jeffries, M.D., Shawano
Robert Krohn, M.D., Black River Falls
E. P. Ludwig, M.D., Wausau
P. B. Mason, M.D., Sheboygan
Howard Mauthe, M.D., Fond du Lac
A. J. McCarey, M.D., Green Bay
R. M. Moore, M.D., Frederic
E. J. Nordby, M.D., Madison
C. G. Reznichek, M.D., Madison
L. O. Simenstad, M.D., Osceola
John T. Sprague, M.D., Madison
F. H. Wolf, M.D., La Crosse
L. H. Lokvam, M.D., Kenosha
N. A. Hill, M.D., Madison

RECOMMENDATION OF REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Commended the Commission for its work and pointed out that the improved status of its programs should add to every member's pride and confidence in the work of this Commission. The Committee recommended acceptance of the report of the Commission on Medical Care Plans.

The Reference Committee also considered the statement of the Commission forwarded through the supplementary report of the Council. To clarify a statement in the report, the Committee pointed out that the Commission used the word "local" to refer to the individual Blue Shield plans rather than to refer to communities within each state. With that clarification, the Committee recommended adoption of the statement.

HOUSE OF DELEGATES ACTION—Adopted the report of the Commission on Medical Care Plans as recommended by the Reference Committee and adopted the statement of the Commission forwarded through the supplementary report of the Council as clarified by the Reference Committee.

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KENOSHA COUNTY MEDICAL SOCIETY RESOLUTION

Honoring L. H. Lokvam, M. D.

David N. Goldstein, M. D., Kenosha, president of Kenosha County Medical Society: Thank you very much for the privilege of the floor for the purpose of reading a resolution that was passed unanimously by the Kenosha County Medical Society during its regular monthly meeting on May 4, 1962:

> "*Resolved*, That in grateful appreciation of the highly commendable service of their colleague, Leif Henry Lokvam, M. D., as President of the State Medical Society of Wisconsin in 1961–1962, having performed his duties with great ability and high statesmanship, thereby adding to the distinction of his high office and bringing credit to his own component society, the Kenosha County Medical Society does herewith contribute $1,000 to the State Medical Society Charitable, Educational and Scientific Foundation in his honor."

The check has been presented to the Secretary, and it is now my pleasure to present a copy of this resolution to Doctor Lokvam.

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STATEMENT OF J. W. McROBERTS, M. D., SHEBOYGAN

In an editorial in a Milwaukee newspaper tonight (May 8, 1962), it was stated: "The 250 New Jersey doctors who threaten not to treat patients under the Administration's proposed medical care program signed the wrong prescription."

To the best of our knowledge, the New Jersey physicians have not in fact even intimated that they would refuse to render medical aid, but only that they would refuse to complete the reports or

REFERENCE COMMITTEE ON NOMINATIONS. Pictured above are a portion of the committee, left to right: Dr. G. L. Rothenmaier, Racine; W. P. Curron, Antigo; R. E. McMahon, La Crosse; C. J. Picard, Superior; C. E. Koepp, Morinette; and G. E. Collentine, Jr., Milwaukee.

accept the payments authorized under the King-Anderson bill.

However, the implication of the action in New Jersey and the reports about it requires that we physicians in Wisconsin make our position unmistakably clear.

At no time, under any circumstances, will we as physicians refuse to render medical care to any of our patients who need it solely because of the mechanism of payment for such services.

This in no way lessens our criticism of King–Anderson type legislation which we feel would be detrimental to patient health and welfare.

HOUSE OF DELEGATES ACTION—Accepted Doctor McRoberts' statement.

COMMITTEE ON NOMINATIONS

District	*Member*
First	L. W. Schrank, M.D., Waupun
Second	G. L. Rothenmaier, M.D., Racine
Third	M. D. Davis, M.D., Milton
Fourth	W. D. Hamlin, M.D., Mineral Point
Fifth	T. H. Rees, M.D., Manitowoc
Sixth	D. J. Twohig, Jr., M.D., Fond du Lac
Seventh	R. E. McMahon, M.D., La Crosse
Eighth	C. E. Koepp, M.D., Marinette
Ninth	M. V. Overman, M.D., Neillsville
Tenth	P. H. Gutzler, M.D., River Falls
Eleventh	C. J. Picard, M.D., Superior
Twelfth	G. E. Collentine, M.D., Milwaukee
Thirteenth	W. P. Curran, M.D., Antigo

HOUSE OF DELEGATES ACTION—Accepted the Committee on Nominations as selected by each district in caucus.

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REPORT OF THE COMMITTEE ON NOMINATIONS

C. J. Picard, M. D., Superior, Chairman

ELECTION OF OFFICERS

The following nominees were presented for positions in the State Medical Society as follows:

President-elect—W. J. Egan, M.D., Milwaukee (to succeed N. A. Hill, M.D., Madison)

Speaker—R. E. Callan, M.D., Milwaukee (to succeed himself)

Vice-speaker—H. W. Carey, M.D., Lancaster, (to succeed himself)

Delegates to AMA—L. O. Simenstad, M.D., Osceola (to succeed himself); E. L. Bernhart, M.D., Milwaukee (to succeed himself)

Alternate delegates to AMA—J. M. Bell, M.D., Marinette (1963–1964) (to succeed himself); C. J. Picard, M.D., Superior (1963–1964) (to succeed J. M. Sullivan, M.D., Milwaukee)

HOUSE OF DELEGATES ACTION—Having no further nominations from the floor, the House approved the nominations as recommended by the Committee.

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SITE OF THE 1963 ANNUAL MEETING

The Committee on Nominations recommended that Milwaukee be the site of the 1963 annual meeting.

HOUSE OF DELEGATES ACTION—Approved Milwaukee as the 1963 annual meeting site.

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ELECTION OF COUNCILORS

Nominations for councilors were presented by the elected delegates of the county medical society or societies in the district which the councilor represented as follows:

District	*Nominee*
Third	M. D. Davis, M.D., Milton (additional councilor)
Sixth	George Nadeau, M.D., Green Bay (additional councilor)

District	*Nominee*
Seventh	J. C. Fox, M.D., La Crosse (to succeed himself)
Eighth	J. M. Bell, M.D., Marinette (to succeed himself)
Ninth	R. W. Mason, M.D., Marshfield (to succeed himself)
Tenth	R. C. Frank, M.D., Eau Claire (to succeed himself)
Twelfth	S. L. Chojnacki, M.D., Milwaukee (to succeed W. J. Egan, M.D., Milwaukee)
	S. W. Hollenbeck, M.D., Milwaukee (to succeed the late J. W. Fons, M.D., Milwaukee)
Thirteenth	W. P. Curran, M.D., Antigo (to succeed himself)

HOUSE OF DELEGATES ACTION—Approved the nominations for councilors as recommended by the respective districts.

RESOLUTION CONCERNING NATIONAL HOSPITAL WEEK

The Speaker presented a resolution for consideration of the House:

WHEREAS, Hospital services worthy of the quality which has made American health care the finest in the world are the product of a community of spirit between physicians, hospital personnel and many others of civic and charitable interest, and

WHEREAS, The people of Wisconsin enjoy a superior type of hospital service provided through excellent facilities; now, therefore, be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin acknowledge National Hospital Week with a tribute to those who daily work in health and comfort of all patients; and be it further

Resolved, That this House express its high regard for the leadership of the Wisconsin Hospital Association and the Wisconsin Conference of Catholic Hospitals in their efforts to assure the continuation of high-quality hospital care for the people of Wisconsin.

HOUSE OF DELEGATES ACTION—Approved the resolution.

COMMITTEE ON CREDENTIALS

P. E. Oberbreckling, M. D., Milwaukee, Chairman

G. A. Behnke, M. D., Kaukauna

T. J. Nereim, M. D., Madison

HOUSE OF DELEGATES ACTION—Accepted as the official roll of the first session of the House 62 delegates and 4 alternate delegates entitled to vote.

Accepted as the official roll of the second session of the House 58 delegates, 3 alternate delegates and 2 specially appointed delegates, totaling 63, entitled to vote.

Accepted as the official roll of the third session of the House 64 delegates and 11 alternate delegates, totaling 75, entitled to vote.

ATTENDANCE AT HOUSE OF DELEGATES

May 7, 8, and 9, 1962

SOCIETY:	Sessions 1	2	3
Ashland–Bayfield–Iron			
J. M. Jauquet, Ashland	x	x	o
C. A. Grand, Ashland	x	x	x
Barron–Washburn–Sawyer–Burnett			
C. J. Strang, Barron	x	x	x
R. E. Lund, Cumberland	o	o	o
Brown			
George Nadeau, Green Bay	x	x	x
J. E. Dettmann, Green Bay	x	x	x
J. L. Ford, Green Bay	x	x	x
L. H. Edelblute, Green Bay	x	x	x
Calumet			
E. W. Humke, Chilton	o	o	o
A. C. Engel, New Holstein	o	o	o
Chippewa			
M. W. Asplund, Bloomer	x	x	x
J. J. Sazama, Chippewa Falls	o	o	o
Clark			
M. V. Overman, Neillsville	x	x	x
R. L. Hansen, Colby	o	o	o
Columbia–Marquette–Adams			
R. T. Cooney, Portage	x	x	x
R. R. Rueckert, Portage	x	x	x
Crawford			
M. S. Garrity, Prairie du Chien	x	x	x
T. F. Farrell, Prairie du Chien	o	o	o
Dane			
R. S. Gearhart, Madison	o	o	o
R. L. Beilman, Madison	o	x	x
T. J. Nereim, Madison	x	x	x
K. L. Siebecker, Madison	x	x	x
R. N. Allin, Madison	x	x	x
A. J. Richtsmeier, Madison	x	o	o
N. M. Clausen, Madison	x	x	x
R. P. Sinaiko, Madison	o	o	o
H. M. Suckle, Madison	x	x	x
A. E. Cowle, Madison	x	x	x
C. W. Stoops, Madison	o	o	o
P. B. Golden, Madison	x	x	x
W. T. Russell, Sun Prairie	x	x	x
G. J. Derus, Madison	x	x	o
R. A. Straughn, Madison	x	x	x
G. E. Oosterhous, Madison	o	o	x
Dodge			
L. W. Schrank, Waupun	x	x	x
R. E. Urbanek, Beaver Dam	o	o	o
Door–Kewaunee			
W. G. Sheets, Sturgeon Bay	x	x	x
D. E. Dorchester, Sturgeon Bay	x	o	o
Douglas			
C. J. Picard, Superior	x	x	x
R. P. Fruehauf, Superior	o	o	o
Eau Claire–Dunn–Pepin			
D. R. Griffith, Eau Claire	x	x	o
A. A. Drescher, Menomonie	o	o	o
I. L. Blose, Omaha	o	o	o
W. R. Manz, Eau Claire	x	x	x

First name is delegate, indented name is alternate. x—present. o—absent.

	Sessions 1	2	3
Fond du Lac			
D. J. Twohig, Jr., Fond du Lac	x	x	x
W. E. Myers, Fond du Lac	o	x	o
Forest			
E. F. Castaldo, Laona	o	o	o
B. S. Rathert, Crandon	o	o	o
Grant			
C. L. Steidinger, Platteville	x	x	x
H. W. Carey, Lancaster	x	x	x
Green			
R. G. Zach, Monroe	x	x	x
W. J. Staab, Monroe	x	x	x
Green Lake—Waushara			
F. G. Slattery, Wautoma	x	o	o
G. G. Mueller, Princeton	o	o	o
Iowa			
W. D. Hamlin, Mineral Point	x	x	o
S. B. Marshall, Hollandale	o	o	o
Jefferson			
H. G. Mallow, Fort Atkinson	o	x	x
R. R. Liebenow, Lake Mills	x	o	o
Juneau			
M. S. Tverberg, Mauston	x	x	x
J. S. Strong, Mauston	o	o	o
Kenosha			
R. W. Ashley, Kenosha	x	x	x
G. C. Schulte, Kenosha	x	o	x
La Crosse			
R. E. McMahon, La Crosse	x	x	x
K. P. Ruppenthal, Bangor	o	o	o
D. L. Morris, West Salem	x	x	x
G. E. Skemp, La Crosse	o	o	o
Lafayette			
R. E. Oertley, Darlington	x	x	x
R. E. Hunter, Argyle	o	o	o
Langlade			
W. P. Curran, Antigo	x	x	x
D. W. Dailey, Elcho	o	o	o
Lincoln			
R. J. Henderson, Tomahawk	x	x	o
J. F. Bigalow, Merrill	o	x	x
Manitowoc			
T. H. Reese, Manitowoc	x	x	x
W. F. Smejkal, Manitowoc	o	x	x
Marathon			
E. P. Ludwig, Wausau	x	x	x
W. T. Becker, Wausau	x	x	x
Marinette—Florence			
C. E. Koepp, Marinette	x	x	x
J. W. Boren, Jr., Marinette	x	o	o
Milwaukee			
R. F. Purtell, Milwaukee	x	x	x
E. D. Wilkinson, West Allis	x	x	x
S. L. Chojnacki, Milwaukee	x	x	x
Rex Ruppa, Milwaukee	o	x	o
S. E. Zawodny, Milwaukee	x	x	x
J. R. Evrard, Milwaukee	x	o	o
A. J. Sanfelippo, Milwaukee	x	x	x
J. J. Barrock, Milwaukee	o	x	x
Edgar End, Milwaukee	x	x	x
G. W. Dean, Milwaukee	o	o	o
S. W. Hollenbeck, Milwaukee	x	x	x
R. J. Snartemo, Milwaukee	x	x	o
F. A. Ross, Milwaukee	x	x	x
T. J. Cox, Milwaukee	o	x	x
C. M. Schroeder, Milwaukee	x	x	x
K. E. Sauter, Milwaukee	x	x	x
V. L. Baker, Milwaukee	x	o	x
R. T. Sproule, Milwaukee	o	x	x
H. F. Twelmeyer, Wauwatosa	x	x	x
D. W. Calvy, Milwaukee	o	o	o
L. R. Weinshel, Milwaukee	x	x	x
W. S. Polacheck, Milwaukee	x	x	o
H. M. Klopf, Milwaukee	x	x	x
B. J. Peters, Milwaukee	x	o	o
F. E. Drew, Milwaukee	x	x	x
P. G. LaBissoniere, Milwaukee	x	x	x
G. W. Hilliard, Milwaukee	x	x	x
T. F. Jennings, Milwaukee	o	x	x
H. J. Lee, Milwaukee	x	o	x
W. H. Frackelton, Milwaukee	o	o	o
G. E. Collentine, Jr., Milwaukee	x	x	o
R. S. Haukohl, Milwaukee	x	o	x
J. F. Cary, Milwaukee	x	x	x
R. A. Nimz, Milwaukee	o	o	o
W. J. Conen, Milwaukee	x	x	x
E. J. Schmidt, Wauwatosa	x	x	x
P. E. Oberbreckling, Milwaukee	x	x	x
A. E. Roethke, Milwaukee	x	x	x
D. M. Ruch, Milwaukee	x	x	o
K. A. Liefert, Wauwatosa	x	x	x
Norbert Enzer, Milwaukee	o	o	o
R. H. Lillie, Milwaukee	o	o	o
E. G. Collins, West Allis	x	x	x
F. J. Millen, Milwaukee	x	x	x
G. V. Murphy, South Milwaukee	x	x	x
R. H. Frederick, West Allis	x	o	o
N. G. Bauch, Milwaukee	x	o	x
W. L. Coffey, Milwaukee	x	x	x
D. J. Carlson, Milwaukee	x	o	x
R. B. Pittelkow, Milwaukee	x	x	x
E. L. Bernhart, Milwaukee	x	x	x
L. E. Rothman, Milwaukee	o	o	o
Monroe			
C. B. Koch, New Lisbon	x	x	o
R. G. Konicek, Tomah	o	o	o
Oconto			
H. A. Aageson, Oconto	x	o	x
J. R. Culver, Oconto Falls	o	o	o
Oneida—Vilas			
M. Wright, Rhinelander	x	x	x
L. L. Jacobson, Eagle River	o	o	o
Outagamie			
G. A. Behnke, Kaukauna	x	x	x
W. H. Hale, Appleton	o	o	o
J. H. Russell, Appleton	x	x	x
J. G. Bergwall, Hortonville	x	o	o
Ozaukee			
J. F. Walsh, Port Washington	x	x	x
R. H. Dorr, Belgium	x	x	x
Pierce—St. Croix			
P. H. Gutzler, River Falls	x	x	x
C. A. Olson, Baldwin	x	x	x
Polk			
L. O. Simenstad, Osceola	x	x	x
R. M. Moore, Frederick	o	o	o
Portage			
F. E. Gehin, Stevens Point	x	x	x
A. J. Sowka, Stevens Point	x	o	x
Price—Taylor			
L. E. Nystrum, Medford	x	x	x
J. L. Rens, Phillips	o	o	o
Racine			
L. E. Fazen, Jr., Racine	o	x	x
V. J. Burch, Racine	o	o	o
G. L. Rothenmaier, Racine	x	x	x
W. H. Henken, Racine	o	o	o
Richland			
R. E. Housner, Richland Center	x	o	o
D. J. Taft, Richland Center	o	o	o

	Sessions 1	2	3
Rock			
M. D. Davis, Milton	x	x	x
M. F. Purdy, Janesville	o	o	o
D. M. Clark, Beloit	x	o	x
J. C. Beltran, Beloit	o	o	o
Rusk			
H. F. Pagel, Ladysmith	x	o	x
M. L. Whalen, Bruce	o	o	o
Sauk			
E. V. Stadel, Reedsburg	x	x	x
J. A. Tibbitts, Reedsburg	o	o	o
Shawano			
D. A. Jeffries, Shawano	o	o	o
H. F. Laufenburg, Shawano	x	x	x
Sheboygan			
J. W. McRoberts, Sheboygan	x	x	o
D. M. Rowe, Kohler	o	o	x
Trempealeau–Jackson–Buffalo			
E. P. Rohde, Galesville	x	x	x
W. E. Wright, Mondovi	x	x	x
Vernon			
C. A. Ender, Viroqua	x	x	x
L. F. Gulbrandsen, Viroqua	o	o	o
Walworth			
J. E. Martin, Jr., Delavan	x	x	x
R. S. Galgano, Delavan	x	x	o
Washington			
E. C. Quackenbush, Hartford	x	x	o
W. A. Nielsen, West Bend	o	o	x
Waukesha			
J. V. Bolger, Waukesha	x	o	x
Aaron Sweed, Waukesha	o	x	o
R. C. Feulner, Waukesha	x	o	x
D. J. Heyrman, Menomonee Falls	o	o	o
Waupaca			
O. E. Larson, Clintonville	o	x	x
M. O. Boudry, Waupaca	o	o	o
Winnebago			
E. A. Strakosch, Oshkosh	x	x	x
S. J. Graiewski, Oshkosh	x	o	o
C. G. Kirchgeorg, Neenah	x	x	x
H. J. Colgan, Neenah	o	o	o
Wood			
E. C. Glenn, Wisconsin Rapids	o	x	x
W. B. Larkin, Marshfield	o	x	x

SECTION:

General Practice			
R. R. Richards, Eau Claire	x	x	x
J. A. Kelble, Milwaukee	o	x	x
Internal Medicine			
L. J. Kurten, Racine	o	o	o
R. L. Gilbert, La Crosse	x	o	o
Neurology and Psychiatry			
L. F. Jenk, Milwaukee	x	x	x
J. R. Hurley, Milwaukee	o	o	o
Obstetrics–Gynecology			
A. A. Cantwell, Shawano	x	x	x
Ophthalmology–Otolaryngology			
R. T. Schmidt, Green Bay	o	x	x
F. G. Treskow, Milwaukee	x	o	o
Orthopedics			
P. K. Odland, Janesville	o	o	o
M. W. Nelson, Racine	o	x	o
Pathology			
J. L. Teresi, Milwaukee	x	x	x
L. W. Kleppe, Beloit	o	o	o
Pediatrics			
J. P. Conway, Milwaukee	x	o	o
Public Health			
E. E. Bertolact, Milwaukee	x	x	x
G. M. Shinners, Green Bay	o	o	o
Radiology			
Howard Mauthe, Racine	x	x	x
L. E. Jones, Racine	x	x	x
Surgery			
J. T. Mendenhall, Madison	x	o	x
R. B. Larsen, Wausau	o	o	x
Urology			
F. M. Hilpert, Racine	x	x	o
A. J. Jacobsen, Racine	o	o	o

Minutes of Council Meeting

Milwaukee, May 6, 1962

1. Call to Order and Roll Call

The meeting was called to order by Chairman Fox at 2:00 p. m. on Sunday, May 6, 1962, at the Hotel Schroeder in Milwaukee.

All voting members of the Council were present. Officers and others present were: President Lokvam, President-elect Hill, Treasurer Weston, Speaker Callan, Vice Speaker Carey; Doctors Simenstad, Bernhart and Galasinski, delegates to the American Medical Association; Doctors Collentine and Sullivan, alternate delegates; Doctors Heidner, J. F. Walsh, reference committee chairman, and C. E. Koepp (Sunday evening); Messrs. Crownhart, Thayer, Ragatz, Hansen, Toser, Murphy, Gill and White; Hall Sprague of Booz, Allen and Hamilton; Mrs. Anderson, Misses Rendall and Pyre.

2. Approval of Minutes of Annual Meeting of Council

On motion duly made, seconded and carried, minutes of the Annual Council Meeting, February 24–25, 1962, were approved.

3. Report of Committee on Economic Medicine Doctor Egan, Chairman

a. AMA Commission on the Cost of Medical Care

By way of review, the committee reported that in 1957 the Council appropriated $10,000 to the Charitable, Educational and Scientific Foundation for a study of physicians' responsibilites in the costs of hospitalization with a view to clarifying the public understanding of "medical care" as this term commonly is used to include all segments of the total cost of health care.

Before this study got under way, the AMA organized a Commission to examine details of the factors determining medical care price and expenditures.

In due course the Foundation authorized transfer of the $10,000 to the AMA so as not to duplicate a study which seemed to fall precisely within the purpose of the AMA Commission. There were "no strings attached" to the Wisconsin contribution, although it was suggested that the Commission might wish to conduct some part of its work in this state.

At the November 1961 meeting of the AMA, this Commission reported that it planned to use the Wisconsin donation for a comprehensive study of solo and group practice with regard to the financing of medical care.

Briefly, the AMA Commission proposes:

(1) A pilot study primarily for the purpose of determining whether useful data and comparisons can be obtained concerning the differences, if any, which may exist in the costs to the public for medical services provided through solo practice and group organization of physicians.

(2) The selection of a Wisconsin community of about 50,000 or more population with at least one established medical group and an equal or greater number of solo practitioners, including both generalists and specialists.

(3) The study of both hospitalized and non-hospitalized cases in 10 disease categories. Cases will be divided equally between patients under the care of solo practitioners and physicians affiliated with a group.

(4) Adequate provision would be made for safeguarding of privilege. No findings would be released without prior clearance by the Council.

(5) A two-man team of AMA staff personnel to conduct pilot study with part-time assistance from a State Medical Society staff member. It is hoped the pilot study can be completed within the next three to four months.

The proposed pilot study was discussed in detail with the committee by Mr. C. Joseph Stetler and Mr. John Rowland of the AMA staff assigned to the Commission.

The Committee on Economic Medicine reported that it recognized the pilot nature of the project for the primary purpose of determining whether a more comprehensive study may be feasible, and also recognized that any conclusions obtained from this pilot study probably could not be considered statistically significant.

The committee recommended to the Council that with the qualifications mentioned above, the pilot study be authorized and any findings or reports resulting from the study be cleared with the Council prior to release.

On motion of Doctors Egan–Bell, carried, the recommendation was approved.

b. Hospital Pharmacies

The committee reported its consideration of several reports of problems concerned with pharmacy regulations as they affect medical care in the hospital.

On motion of Doctors Blanchard–Nordby, carried, the Council adopted a statement relative to hospital pharmacies proposed by the committee, which may be found in the supplementary report of the Council to the House of Delegates.

c. Medical Economic Conference

The committee's recommendation that the Council proceed to implement a one-day medical economic conference on a pilot basis, as earlier authorized, was laid over.

d. Resolution of the Maryland Medical Society

The committee reported its discussion of a resolution of the Maryland Medical Society to the effect that boards of medical examiners include questions dealing with ethics and proper socio-economic practices in state board examinations for licensure. The committee was sympathetic with this proposal, but felt that a more basic problem was that of more adequate preparation of the medical student on these subjects during his formal medical education. It therefore recommended that this resolution be referred to the Planning Committee which already has other aspects of the same problem under consideration.

On motion of Doctors Egan–Houghton, carried this recommendation was approved. On further motion of Doctors Egan–Houghton, carried, the report as a whole was adopted.

The Council agreed with the suggestion of Chairman Fox that the statement on hospital pharmacies be distributed to all hospitals, hospital pharmacies, and chiefs of staff in the state.

4. Power of Subpoena; Chapter 113, Laws of 1961

Mr. Murphy discussed the effects of this law, and suggestion by the president of the State Bar of Wisconsin that joint consideration be given to establishing some acceptable ground rules for taking of medical, depositions under its terms.

Mr. Crownhart suggested that this would be an appropriate subject for the Grievance Committee, which worked with a committee of the Bar several years ago in development of the Interprofessional Code.

On motion of Doctors Houghton–Dessloch, carried, the Grievance Committee was requested to meet with the designated committee of the State Bar to discuss the question.

5. Report of Finance Committee Doctor Dessloch, Chairman

a. Employees' Pension Plan

The committee reported that, as trustees of the Pension Plan, it is considering some amendments chiefly of a clarifying nature, the principal one being to provide a mechanism for pay-out at the time of death of an employee, and the other relating to pay-out during the year when employment is terminated by the employee himself and under honorable circumstances.

b. Society Advance to CES Foundation

On motion of Doctors Dessloch–Nordby, carried, the Council approved the recommendation of the Finance Committee that the indebtedness of the Foundation to the Society for working capital advanced for Foundation purposes, some dating back to 1957, be cancelled, thus enabling the Foundation to establish more workable credit on several of its projects.

c. Financial Reports

Doctor Dessloch asked Mr. John White to discuss the summary report of financial condition and income and expenditures of the State Medical Society and its related activities which had been prepared as in 1961 at the request of the House of Delegates.

On motion of Doctors Dessloch–Nordby, carried, the report of the Finance Committee was accepted as a whole.

6. Relation of Psychology to the Practice of Medicine

A draft report by a committee had been sent to Councilors and Officers in advance of the meeting after initial review by the Executive Committee.

On motion of Doctors Nordby–Houghton, carried, the report was referred to the Grievance Committee which has considered matters in the past concerning groups ancillary to medicine.

Doctor Galasinski suggested that any study of the matter be held until after the next meeting of the American Medical Association which is likely to have related matters before it.

7. Report of Commission on Medical Care Plans

Doctor Dessloch reported as a matter of information that for several reasons the writing of an endorsement to WPS contracts to provide indemnification for services by podiatrists seemed to be indicated. This will be cleared with the Commission before it is offered for sale.

He also presented a statement of the Commission's Executive Committee as to its current position in the matter of uniform national account contracts and proposals for health care of senior citizens.

On motion of Doctors Houghton–Egan, carried, the statement was approved by the Council for transmittal to the House of Delegates, and will be found in the supplementary report of the Council.

8. Executive Session

The Council went into executive session at 3:50, recessed at 5:45, and reconvened at 8:00 p. m., after which the following actions were taken as to matters discussed in executive session, and as to new business subsequently introduced:

a. On motion of Doctors Egan–Bell, carried, the Council directed that the officers, in collaboration with the staff, proceed along educational lines for patient-citizen welfare and that these steps be taken in a manner legally and statutorily correct.

b. On motion of Doctors Nordby–James, carried, the Council approved a letter to be signed by Chairman Fox disputing Senator Proxmire's recent statement in Milwaukee that "hundreds of thousands of Americans are dying because they can't afford to live."

c. On motion of Doctors Ekblad–Dessloch, carried, the Council approved transmittal to the House of Delegates of a resolution of appreciation to the American Medical Association for the March program for county society presidents and secretaries.

d. On motion of Doctors Nordby–Ekblad, carried, the Council disapproved introduction to the House of three resolutions from county societies because of their lateness of filing.

e. On motion of Doctors Blanchard–Bell, carried, the Council approved forwarding to the House a resolution presented by Doctor Willson for the Milwaukee councilors condemning King–Anderson legislation. A motion by Doctors Dessloch–Bell to amend the resolution to include support of Kerr–Mills legislation was carried.

f. On motion of Doctors Dessloch–Schulz, carried, a resolution presented by Doctor Van Hecke concerning the practice of pathology and supervision of commercial laboratories was approved for transmittal to the House of Delegates.

g. On motion of Doctors Ekblad–James, carried, the Council forwarded to the House the text of a letter from the Council on Medical Service of the American Medical Association expressing appreciation for the service of Ervin L. Bernhart, M. D., of Milwaukee, on its Committee on Insurance and Prepayment Plans.

h. On motion of Doctors Nordby–Frank, carried, the Council affirmed the recommendation of the Commission on Hospital Relations and Medical Education that the Hayward Area Community Hospital receive the Society's Hospital Achievement Award in 1962.

i. Commission on Public Policy. Doctor Fox reported on a conference with the chairman of this commission, the president, president-elect, and speaker of the House. It was concluded that the connission would make no report to the House of Delegates this year, but that one or more meetings of the commission will be arranged prior to the July meeting of the Council to prepare specific recommendations with reference to the chiropractic problem in this state; that in order to make a program of the Commission on Public Policy effective relative to chiropractic, the officers of the Society and the appropriate staff should see to it that essential liaison is established with the Board of Basic Science Examiners, the Board of Medical Examiners, and the Wisconsin Division of the American Cancer Society; and that a conference on quackery be planned in this state for sometime this fall. Doctor Fox said that he had invited Doctor Zach to make a personal presentation to the July meeting of the Council of the report and recommendations of the Commission on Public Policy with reference to the problem of chiropractic and any other matters it wishes considered for the 1963 session of the Legislature.

9. Costs of Management Survey

Doctor Willson said that in prior discussions of the adequacy of the special assessment, Mr. Crownhart had properly brought out that the Society would incur expenses over and above direct billings by the firm of management consultants conducting the survey. He said that the directors of Milwaukee County were also concerned about compensation for excess demands, and moved that the expenses over

and above normal expenses of any county medical society incurred during any period of the survey be compensated out of the special assessment. Motion seconded and carried.

In discussion, Doctor Nordby said he thought this was reasonable and proper, and that expenses should be submitted at the close of the survey for audit and proper payment.

10. Report of Executive Committee Doctor Lokvam, Chairman

"The committee, meeting last night, engaged in some routines including a review of projects pending in the Planning Committee and in the Committee on Economic Medicine. The pending file of the Executive Committee is up to date, as are those of the Finance Committee and the Committee on Scientific Medicine. This is an annual inventory of projects and their status.

"It learned of a proposal of the State Board and Department of Nursing to study whether there are in this state graduate nurses who hold themselves out as registered or as trained practical nurses when neither status has been achieved. It is inviting a special meeting with the state board of nursing to review the project further.

"It recommends to the Council that it approve a request to the secretary of the State Board of Medical Examiners to initiate application of the Basic Science Law to practitioners of podiatry. The substantially expanded privileges of podiatrists, particularly in the area of writing prescriptions except for narcotics, supports the reasonableness of the request. For a long time the Basic Science Law has been held applicable to podiatry, but technical compliance has in effect been waived. This no longer seems to be practical.

"The committee learned of requests that the Council introduce resolutions—one to look into the matter of a committee to mediate professional liability claims, and another to reassure the public that where financial need exists on the part of a patient, physicians will reduce their fees compatible with the income of the patient. As to the former, this subject is under study now by the Committee on Economic Medicine and a resolution to the House would be superfluous. As to the latter, this has been so repeatedly stated that to issue another proclamation on the point might appear as a lack of confidence in our colleagues.

"Some 20 years ago the Society enacted a bylaw specifying how sections of specialty and specially interested groups may be formally recognized, and among other things, provided that a section should have delegate representation. This is an anomalous situation inasmuch as the State Medical Society is composed of a union of county medical societies and delegate representation in the case of county medical societies is based upon the total membership of each society. Providing a voting delegate to sections lessens the effective voice in the House by those representing county societies rather than a special interest.

"This has been discussed at length and it is recommended that Section 6 of Chapter 13 of the Bylaws be amended to continue the privilege of sections to elect a delegate and an alternate delegate, but without the right of a vote in the House.

"We point out that while there are 12 sections now, the possibility exists of there being as many as 25–30, and action should be taken now before the problem becomes more complicated by time and the development of further specialty groups."

(In another item on the agenda, the Planning Committee reported its recommendation that the Council take action to approve the request of the dermatologists that a Section on Dermatology be created, and report this to the House of Delegates for ratification.)

Doctors Lokvam–Egan moved that the report of the Executive Committee, quoted above, be adopted.

Doctors Willson–Van Hecke offered an amendment that the portion disenfranchising section delegates be deleted.

Doctors Sorenson–Ekblad moved to amend the amendment that the question be referred to the Planning Committee; that a section on Dermatology be accepted with voting privileges; and that hereafter no more sections be admitted until the structure and organization of the State Medical Society has been studied.

Motion carried as amended.

11. Menominee County

a. Assignment to Councilor District

On motion of Doctors Dessloch–Curran, carried, the new county was assigned to the Eighth Councilor District.

b. Survey of Health Needs

On motion of Doctors James–Willson, carried, the Council requested the CES Foundation to implement physician direction of a health study of the new county, seeking assistance of welfare and other interested agencies.

12. Commission on State Departments Elections

On motion duly made, seconded and carried, the following were elected to the Commission on State Departments for the ensuing year:

T. W. Tormey, M. D., Madison, General Chairman

L. M. Simonson, M. D., Sheboygan, Vice-Chairman and Division on School Health Chairman

Other Division Chairmen:

A. M. Hutter, M. D., Fond du Lac, Division on Aging

H. A. Anderson, M. D., Stevens Point, Division on Chest Diseases

J. W. Nellen, M. D., Green Bay, Division on Handicapped Children

John Evrard, M. D., Milwaukee, Division on Maternal and Child Welfare

Keith Keane, M. D., Appleton, Division on Nervous and Mental Diseases

H. W. Carey, M. D., Lancaster, Division on Public Assistance

Ray Piaskoski, M. D., Milwaukee, Division on Rehabilitation

R. B. Windsor, M. D., Sheboygan, Division on Safe Transportation

Meyer S. Fox, M. D., Milwaukee, Division on Visual and Hearing Defects

13. Adjournment

The meeting adjourned at 9:15 p. m.

C. H. Crownhart
Secretary

Approved:
James C. Fox, M. D.
Chairman

the Wisconsin Medical Journal

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Two Years' Experience in Treatment of Burns in a Private General Hospital

By GEORGE E. COLLENTINE, M. D., JOHN D. CONWAY, M. D., WALTER WOLOSCHEK, M. D., and BURTON WAISBREN, M. D.

Milwaukee, Wisconsin

A SPECIAL facility for the care of burns was opened at St. Mary's Hospital, Milwaukee, in August, 1959. The purpose of this report is to review the experience of the first two years of operation of this unique enterprise in a private community general hospital.

THE UNIT

The burn unit occupies about 800 square feet of space on the fifth floor (Fig. 1) and is divided into:

(1) A central admitting and treatment room, also used as a nurses' station, with two sets of scrub sinks and extensive storage-cupboard and working-counter space.

(2) An adjoining hydrotherapy alcove, housing a 93x45x22-inch stainless steel tub with whirlpool aerator and an overhead electric hoist riding on an I-beam attached to the ceiling to facilitate lifting patients on a special stretcher from bed to tank.

(3) Two double patient rooms with four CircOlectric Stryker beds.

Air in the unit is mechanically circulated to accomplish complete exchange 10 times per hour; temperature and humidity are controlled; the air is mechanically and electrostatically filtered, irradiated with ultraviolet light and slightly pressurized so that no general hospital air enters the unit when the door is opened.

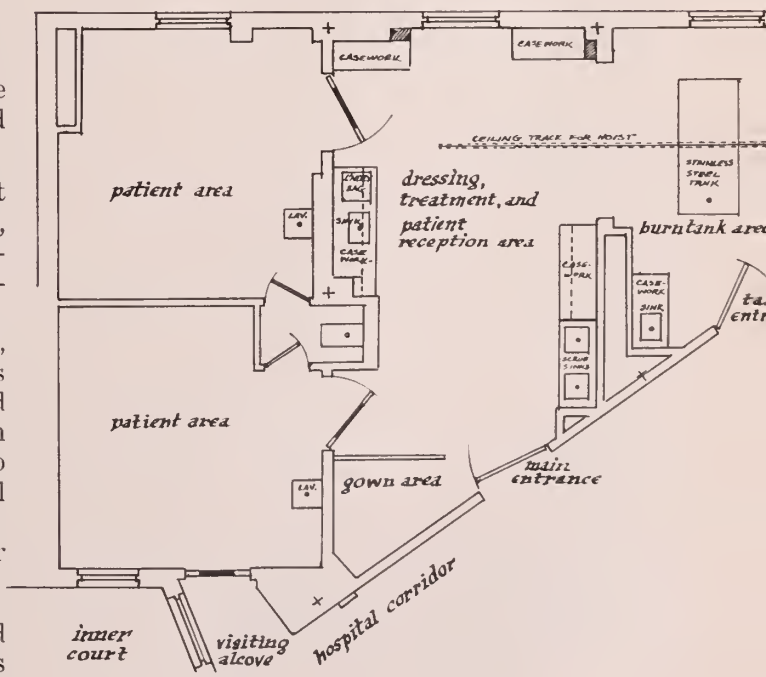

Fig. 1—Floor plan of burn unit.

All personnel entering the unit don mask, cap and gown, wipe their feet on an antiseptic-soaked pad and wash their hands. An intercommunication system permits conversation between the patients, nurses at the central station, and visitors in a small visitors' alcove outside the unit.

MATERIAL

Opening of the unit was followed by a progressive increase in the number of burn admissions, which still continues. Whereas in the previous 10 years the average annual rate of admissions had been less than 10 per year, 107 patients entered with burns as the principal diagnosis between Aug. 1, 1959, and July 31, 1961. Of these, 85—26 in the first year and 59 in the second—were treated in the burn unit and constitute the patient material of this report. (Fig. 2). The other 22 patients include no major or fatal burn problems, and they were cared for on general floors by members of the staff other than the burn team.

The burn team consists of three general surgeons and one internist, with consulting plastic surgeons, orthopedists, ophthalmologists and physiatrists participating as indicated. For a period in the summer of 1961, there were 15 inpatients under the care of the burn team; the overflow from the primary unit was managed with varying degrees of isolation technique on the adjoining general surgical or pediatric floors.

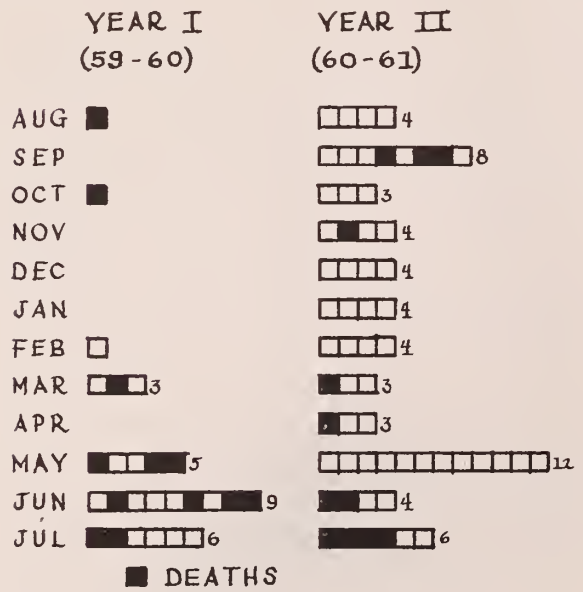

Fig. 2—Monthly admissions first two years.

Patients were admitted directly from the site of injury and also from emergency or other hospitals in Milwaukee and such outlying communities as Ishpeming, Mich., Elkhorn, Waukesha, Kewaskum, Manitowoc, Sheboygan and Port Washington, Wis., after periods of care ranging from a few minutes to several days.

Males outnumbered females two to one. Home accidents were twice as common as industrial (Table 1). Twenty-seven patients were less than 10 years of age; 9 were over 60 (Fig. 3).

Heading the list of causative accidents were home and yard fires and explosions, spilled cooking utensils, and industrial fires and explosions, followed by industrial splashes, powerline contacts, scalding baths, and one stock car racing crash (Table 2). More than half of the victims suffered flame and flash injury; another fourth of the group encountered hot water or steam; other burning agents were electricity, molten metal, hot cooking grease, and caustic chemicals (Table 3).

The burns ranged in extent from 2 per cent third degree burns of hands in a young adult to more than 95 per cent all third degree burns in an 86-year-old man (Fig. 4). Twelve patients had respiratory involvement severe enough to require tracheostomy.

METHOD

Each burn inpatient is seen on admission by one of three receiving general surgeons. The receiving surgeon determines whether the patient requires burn unit care, and he also assumes primary responsibility for

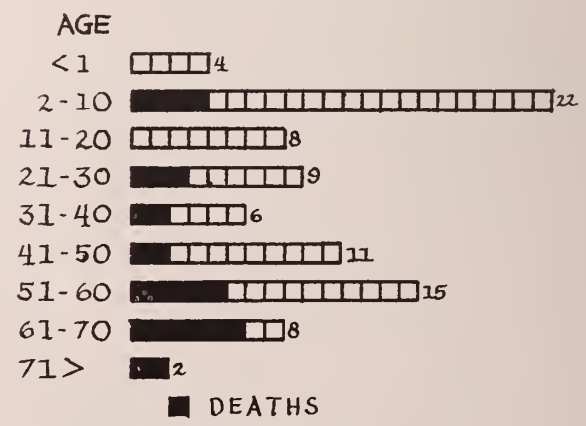

Fig. 3—Distribution by age.

TABLE 1—*Patient Material*

Male	57	(17)
Female	28	(7)
Home accident	56	(15)
Industrial accident	29	(9)

Note: Figures in parentheses ( ) indicate deaths.

TABLE 2—*Nature of Accidents*

Home fires, blasts	33	(14)
Industrial fires, blasts	14	(6)
Industrial splash	9	(2)
Spilled utensil	20	(0)
Scald, bath	2	(1)
Stock car race	1	(1)
Powerline contact	6	(0)

Note. Figures in parentheses ( ) indicate deaths.

TABLE 3—*Causative Agent*

Flame	47	(21)
Hot water, steam	23	(1)
Electricity	6	
Molten metal	3	(2)
Chemicals	3	
Hot grease	3	

Note: Figures in parentheses ( ) indicate deaths.

management, using consultants, including the patient's personal physician, as indicated.

While making his general appraisal of the patient's condition and the severity of the local injury, he proceeds with assurance of an airway, by tracheostomy if necessary, and securing of a veinway, usually by cutdown and introduction of a polyethylene cannula into an arm vein, when parenteral fluids are required. First infusions given are plasma or Lactated Ringers Solution. Small doses of morphine or meperidine hydrochloride are given intravenously for pain and apprehension.

Initial local care consists of gentle cleansing with hexachlorophene (Phisohex) and water, using cotton balls or Webril pledgets, and minimal superficial debridement of blisters and loose tags and tatters of skin. An occasional grossly soiled patient, whose

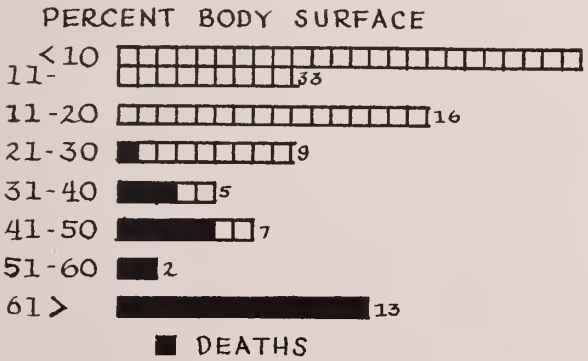

Fig. 4—Distribution by extent of burn.

condition permits more handling, is immersed in a tub of warm water and cleansed there. An indwelling urethral catheter is placed in position. Then the patient is transferred to bed on sterile sheets and covered with sheets over cradles. All burns are exposed as much as possible, and the patient is turned frequently if there is circumferential involvement.

The surgeon outlines the extent of burn on a diagram of the body which is divided according to the classical "rule of nines." Different colors are used to designate estimated areas of third and second degree involvement.[1] From this chart he computes his orders for fluid and electrolyte administration. Here the formula developed at the Surgical Research Unit, Brooke Army Hospital, San Antonio, Texas, has been a most satisfactory guide, subject to modification according to clinical progress, vital signs, and urine output which is measured hourly.[2]

Since December, 1960, a vigorous regimen of combined parenteral and topical antibiotic therapy has been employed according to principles outlined by one of us (B. W.) in a previously published report.[3] This program, as used presently, calls for daily intravenous administration of 6 to 9 gm. chloramphenicol, 6 gm. methicillin, 10,000,000 units penicillin G, and 10 ml. gamma globulin for periods of a few days to more than two weeks, often beginning on the day of injury. While chloramphenicol is being administered, 5 mg. of folic acid and 1,000 mcg. of vitamin B_{12} are given intramuscularly daily to prevent antibiotic glossitis and possible bone marrow depression. No significant drug toxicity has been encountered.

Daily hexachlorophene bed or tub baths are continued, but in addition the nurses "dab" all burned areas at least four times daily with cotton pledgets soaked in a solution containing 1 gm. chloramphenicol, 1,000,000 units penicillin G, 1 gm. neomycin, 100 mg. polymyxin B, in one liter of saline. The content of neomycin and polymyxin is lessened when renal function is impaired. Polymyxin combined with oxytetracycline is used intravenously when warranted by proven or suspected invasion of the blood stream by Pseudomonas aeruginosa.[4] Frequent surface and blood cultures are obtained.

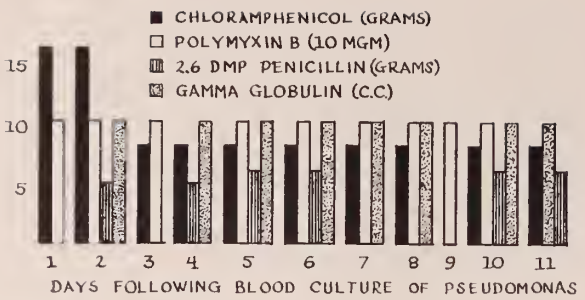

Fig. 5—Complications.

Other routine laboratory determinations in the first five days are daily blood cell counts, reticulocyte counts, urea nitrogen, chlorides, carbon dioxide, sodium, potassium, proteins, and urinalysis.

Oral nutrition, with an ultimate goal of 4,000 calories per day, is encouraged as soon as tolerated. Tube feeding with a mixture containing a dozen eggs and a cup of sugar in a quart of homogenized milk has been helpful and well tolerated in some instances. Plasma and blood are used, especially when skin grafting sessions are imminent, to raise the level of hemoglobin above 12 gm. per 100 ml. and proteins above 6 gm. per 100 ml. Patients are weighed daily and caloric intake is charted daily.

For major debridements and skin grafting, patients are transported to the operating room. However, surprisingly extensive eschars of third degree burns have been eliminated and the areas prepared for grafting by what might be termed "medical debridement"—that is, the constant teasing away of crust edges as part of the "dabbing" process, in addition to actual debridement in the whirlpool tub without anesthetics. The nursing staff has become very proficient in this procedure. Similarly, the more superficial crusts of many second degree burns have been dealt with completely without anesthetics.

RESULTS

In the first year of operation 14 survived of the 26 patients admitted; in the second year, 47 of 59 survived. Four deaths occurred among the 27 patients who were younger than 10 years of age; 11 died among the 61 who were younger than 50 years of age; 13 died of 24 patients who were older than 50 (Fig. 5).

Only one patient with total burns of less than 30 per cent of the body surface failed to survive. This aged man had 30 per cent third degree burns, but also severe respiratory burn unrelieved by tracheostomy. It is noteworthy that none of 12 patients requiring tracheostomy survived. No patient with more than 50 per cent involvement was salvaged.

The two most extensively burned patients who survived suffered 50 per cent and 45 per cent deep second degree injuries which healed without debridement under anesthesia or skin grafting.

A 5-year-old girl with 35 per cent predominantly third degree burn required three anesthetics for debridement and skin grafting in which some donor sites were used for a second time.

A 33-year-old engineer with 30% of his body surface covered by electrical and thermal burns, of which 25% were third degree, survived after amputation of the left leg below the knee and all but the great toe on the right foot; complete destruction of the extensor mechanisms at both wrists; excision of a mycotic aneurysm of the right radial artery at the wrist following two hemorrhages; six debridements under anesthesia, with two involving drilling of exposed radius and tibias and three skin grafting sessions. He received 126 gm. of chloramphenicol, 40 gm. of methicillin, 90 ml. of gamma globulin and 1,000 mg. of polymyxin B in a 15-day period after Pseudomonas aeruginosa had been identified in a blood culture. Figure 4 represents 11 days of this treatment. During the 80 days before skin covering was completed, he required 24 units of blood and 13 units of plasma.

Autopsies were obtained in 16 of the 24 patients who died. Even with postmortem examination it was often difficult to explain many of the clinical phenomena leading to death. Eleven deaths were attributed to massive extent of surface burn itself. Five had evidence of overwhelming respiratory burn, some with complete slough of the tracheobronchial mucosa. Five had sepsis due to Pseudomonas organisms, proven on culture or strong clinical evidence. One patient died of congestive heart failure associated with hyperkalemia of total renal failure; one of apparent adrenal failure; one with massive coronary arterial thrombosis (Table 4).

The most frequently encountered complication (Table 5) was surface infection, with

TABLE 4—*Cause of Death*

Extent, depth of burn	11
Respiratory burn	5
Pseudomonas septicemia	5
Congestive failure with renal failure	1
Adrenal insufficiency	1
Coronary thrombosis	1

TABLE 5—*Complications*

Clinical surface infection	15
Clinical septicemia	8
Proven septicemia	
Staphylococcus aureus	2
Pseudomonas acruginosa	4
Pneumonitis	12
Bleeding peptic ulcer	2
Significant thrombophlebitis	3
Toxic encephalopathy (D. T.)	1
Aneurysm, radial artery	1
Congestive heart failure	2
Bone exposure	3
Renal failure	4

15 cases of Pseudomonas aeruginosa and 11 cases of coagulase-positive Staphylococcus aureus. These were the most common invaders. Other bacteria encountered were various strains of Streptococcus and Bacillus subtilis, proteus, aerobacter and coli. Candida albicans appeared in 8 cases. Positive blood cultures were obtained in only 6 patients—4 with Pseudomonas and 2 with Staphylococcus organisms, but the clinical courses of at least 2 other fatal cases were very strongly suggestive of Pseudomonas septicemia. Other noteworthy complications included renal failure, often temporary; bronchopneumonia; thrombophlebitis; and bone exposure. Only 2 patients manifested evidence of peptic ulcer during their hospitalization.

COMMENT

An excellent review of surgical principles involved in the treatment of severe burns by Wynn[5] appeared in this Journal in 1961. The methods described above varied from those outlined in that review only in the following details:

(1) The attempt to treat *all* burns by exposure, whether of the hands, circumferential surfaces of trunk or extremities, or not, relying upon sling suspension of extremities and as frequent turning as possible and recognizing that when any burned part lies against the underlying sheet for any extended length of time the underlying sheet acts as a dressing with all of its warmth, darkness and moistness.

(2) The extensive actual sharp debridement of second degree crusts and third degree eschars during daily tubbings, usually beginning before the tenth day after injury and often resuming within the first week after skin grafting.

(3) The infrequency with which homografts were used (only one patient presented a suitable recipient bed when donor material could be obtained; take was equivocal and the patient ultimately succumbed).

Other items of general and local care, grafting and rehabilitation were closely followed in this series.

Variations from the medical principles presented in the same issue of the *Wisconsin Medical Journal* by Waisbren were so minor as to be unworthy of mention.[3]

In the absence of a spectacular "success" with a survival in a patient not expected to live or a prohibitive number of failures in patients expected to survive, no specific conclusions as to efficacy of these methods can be drawn from the results in this series. However, enough clinical experience has been garnered to justify the opinion that the *principles* being followed are as valid as others currently under evaluation in severe burns. Mortality and morbidity data for comparison with other series are being gathered and should eventually give valid comparison with other methods of management.

Of real significance, however, is the fact that the *practicality* of the operation of such a facility in a private hospital under the direction of cooperating private physicians has been tested and established to the satisfaction of staff, administration and, apparently, the community.

Serious problems were encountered early in adequately staffing the unit with nurses and aides. The patient load was entirely unpredictable and these personnel had to be utilized elsewhere in the hospital on a standby basis. It soon became apparent that the care of burns on any acceptable regimen required the services of one nurse and one aide for one patient; a nurse and two aides for two patients; two nurses and three aides for three patients, etc., 24 hours per day. In the face of the current shortage of trained nurses, this seemed, at first, in-

surmountable. However, through the rapid turnover of the early days there emerged a small corps of personnel who were stimulated by the stern challenge to many phases of their skill and training. These have stayed on to form the nucleus of a now fairly sizable team that serves in the unit or its extensions when the patient load swells. The development of standardized procedures for admission and daily care in various stages, with some successes to demonstrate the efficacy of these measures, has bolstered morale considerably. The leadership of an enthusiastic nurse-supervisor has contributed greatly to whatever success has been achieved.

While the concept of private operation of such an enterprise has been vindicated, experience has shown that certain revisions of the physical facility have become necessary. A work and storage room for the folding and wrapping of the mountains of linens to be sterilized has been commandeered. Here volunteers from St. Mary's Guild have given hundreds of hours of valuable service. As has been mentioned, it has often been necessary to overflow, even with newly and critically burned patients, into the adjoining surgical nursing units. The patient rooms have proved to be too small, so that conversion to one three-bed area is contemplated.

A separate screening, treatment and admitting area, where outpatients could be handled more easily, would be desirable.

Further study of ideal environmental temperature for exposed burn patients seems indicated. Patients shiver violently and complain bitterly of intolerable coldness at room temperatures ranging from 72 to over 90 degrees. The role of drafts due to faulty planning of the air purification and distribution system has been important. Radiant heating units have been added recently over the tub and have proved a great comfort to patients being removed therefrom.

One of the patient rooms has only a single window which opens onto a narrow air well, providing no view of outside landscape or even sky. Prolonged stay in this room has produced rather severe disorientation as to time and eating and sleeping habits among several patients. Measures to alleviate this condition are under study, including the provision of mirrors to reflect activity in the general hospital corridors and possibly daylight from the sky; an open intercommunication system to convey the sounds of outside activity; changeable murals for the walls, etc. Of course, radio and television have been valuable diversions and occupational therapy is pushed to the limits of the patients' capabilities.

Dozens of inquiries have been received from all over the world concerning the construction and operation of such a facility, reflecting the widespread awareness of the importance of improved, specialized physical plants in which to deal with this unique surgical problem.

SUMMARY

The experience of the first two years of operation of a special facility for the care of burns in a private general hospital has been reviewed. Major departures from routine therapy were: (1) total exposure treatment of all burns; (2) unusually large doses of parenteral antibiotics; (3) extensive use of sharp debridement in the hydrotherapy tank without anesthetics; (4) "medical debridement" with cotton pledgets soaked in solutions of antibiotic mixtures designed to combat common surface invaders. Results were inconclusive to establish superiority or inferiority of these measures, but the practicality and desirability of such a special physical facility and a team approach to burn care have been affirmed.

2320 North Lake Drive (11).

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A Ten-Year Survey of Testicular Tumors in a General Hospital

By J. D. COLLINS, M. D., and A. P. SCHOENENBERGER, M. D.
Madison, Wisconsin

TESTICULAR tumors are rare entities comprising between 1 and 2 per cent of all malignant lesions in the male.[1,2] The occurrence among World War II armed forces personnel was 3 per 100,000 men for a total of 990.[3] This report reviews the cases of patients admitted to a 350-bed general hospital over a 10-year period.

From January, 1951, through December, 1961, 37 patients were treated at this hospital for benign and malignant neoplasms of the testis and epididymis. The clinical records for these cases were reviewed and the essential features of the history and physical findings were tabulated. In addition, all of the slides from the cases were examined and reclassified according to the scheme of Dixon and Moore.[3] Follow-up information was obtained on all patients through the cooperation of the attending physician. It is noteworthy that this series does not differ to a marked degree from other series of a highly select group of patients. There were, however, several noteworthy observations regarding the types of tumor found, the treatment rendered and the survival following this treatment which had not been reported previously.

CLASSIFICATION

The varied classifications of testicular tumors in early reports were quite confusing and it was only after Dixon and Moore's[3] report that an orderly arrangement was developed. The malignant tumors were divided into nongerminal and germinal tumors with the latter comprising approximately 95 per cent of the group. Four distinct histological groups of the germinal tumors are recognized—seminoma, embryonal carcinoma, teratocarcinoma and choriocarcinoma. These are usually found separately, but in many instances more than one element is present in the tumor. A detailed pathological description will not be presented, for one can easily refer to Dixon and Moore's work.[3] Those tumors in the nongerminal group include interstitial cell, malignant specialized gonadal stromal and adenocarcinoma of the rete tumors.

INCIDENCE OF TUMOR TYPES

The total number of cases was 37 which included 30 malignant tumors and 7 benign tumors. Figure 1 indicates the distribution and frequency of benign tumors according to age. It shows that the majority were adenomatoid tumors, whereas the other tumors listed in this figure are examples of what Mostofi calls specialized gonadal stromal tumors.[4] The tumor listed as infant in this figure is separated from the latter group because the authorities who reviewed it could not agree upon a diagnosis. A consensus of the diagnoses would probably place it in the specialized gonadal stroma category.

Figure 2 indicates the distribution and frequency of malignant tumors according to age. It can be noted that nearly all are germinal tumors and that the majority are seminomas. The average age of all the patients with malignant tumors was 38 years. The seminomas occurred more frequently in a somewhat older age group with an average age of about 40 years, whereas the average age of the remaining patients with germinal tumors was 33 years. In the group of patients with seminoma (Figs. 3 and 4) was a boy only 9 years of age with cryptorchidism. This is a most unusual finding and has been reported elsewhere because of its rarity.[5] The malignant tumor group comprised 28 germinal tumors and 2 lymphosarcomas. Of the germinal tumors there were 14 seminomas, 6 embryonal carcinomas, 4 teratomas and 4 choriocarcinomas.

From the Departments of Pathology and Urology, Madison General Hospital, Madison.

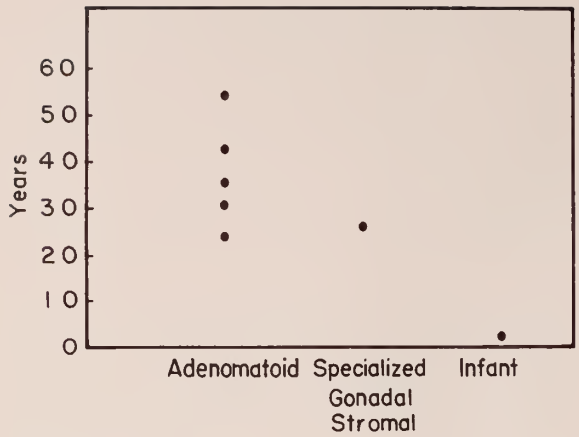


Fig. 1—Distribution and frequency of benign tumors according to age.

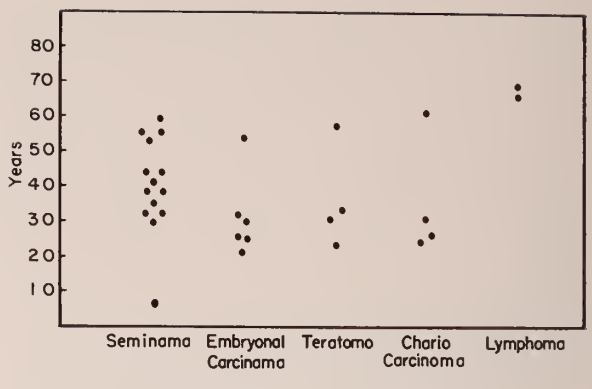


Fig. 2.—Distribution and frequency of malignant tumors according to age.

SIGNS AND SYMPTOMS

Outlined in Table 1 is the frequency of occurrence of the various signs and symptoms in the cases of malignancy. Painless swelling of the involved testis was listed as the most frequent symptom. Pain as a presenting symptom was reported by 11 patients, or slightly over one-third of the patients in this series. Four were associated with hernia or hydrocele and 3 tumors were associated with cryptorchidism. There was a 6 per cent incidence of associated trauma in our series. An unusual feature not depicted in this table was that none of the patients had evidence of metastasis at the time of admission. In other studies, particularly Thompson, et al.,[6] this has occurred in as many as 19 per cent of the cases.

TREATMENT AND RESULTS

All patients with benign tumors were treated by excision of the neoplasm and in no instance was there recurrence. Five of this group included adenomatoid tumors which are usually found attached to the epididymis, but also have been found in the testis and cord. The follow-up studies of the malignant cases are recorded in Table 2. Treatment was carried out in the following manner. All patients with seminoma were treated with orchidectomy and x-ray therapy. Thirteen of the 14 patients have survived a period of 2 years or longer and the other one died of a tumor within 13 months.

The number of patients with embryonal carcinoma is small. Only 1 of them has died of his tumor, and 3 of these patients have survived 5 years or more. The patients in this group all had orchidectomies plus either lymph node dissection or x-ray therapy. The small size of this group does not make it possible to compare the efficacy of treatment.

The patients with teratoma were all treated with orchidectomy and 3 of them received x-ray therapy in addition. Two of the patients have survival periods of longer than 2 years and of the 2 that died only 1 had evidence of tumor.

TABLE 1—*Frequency of occurrence of the various signs and symptoms in the cases of malignancy*

Signs and symptoms	Cases	Percentage
Swelling	24	80%
Pain	11	36%
Associated with hernia or hydrocele	4	13%
Associated with cryptorchidism	3	10%

TABLE 2—*Results of follow-up studies of malignant cases*

Tumor Type	No. of cases with years of survival	Died of Tumor	Died without Tumor
Seminoma	8 with 5 or more years	0	1
	5 with 2 or more years	0	0
	1 with 13 months	1	0
Embryonal	3 with 5 or more years	0	0
	1 with 3 years	0	0
	1 with 1 year	0	0
	1 with 1 year	1	0
Teratoma	2 with 3 years	0	1
	1 with 4 months	0	1
	1 with 2 months	1	0
Chorio-carcinoma	1 with 9 years	0	0
	2 with 1-3 years	0	0
	1 with 7 months	1	0

Three of the 4 patients with choriocarcinoma are still living, 2 of them having survival periods of 3 and 9 years respectively. All were treated with orchidectomy. In addition 2 patients received x-ray therapy and the 2 recent patients had chemotherapeutic agents. It must be noted that the patients with a long survival period have a mixture of the germinal elements and thus are afforded a better prognosis than in pure choriocarcinoma which is 100 per cent fatal.[3] Only 1 case of pure choriocarcinoma was present in our group and this patient survived 7 months. The 2 patients with lymphosarcoma were treated by x-ray therapy, orchidectomy and chemotherapeutic agents and died 3 and 7 months, respectively, after the diagnosis was made. It is most important for the pathologist to recognize this lesion microscopically because it can be incorrectly diagnosed as a seminoma which has a much better prognosis.

As can be seen in Table 2, all those dying of tumor did so within 13 months. The seminomas in our series had an 8 per cent mortality. The remainder of the tumor categories have too small a number for calculation of significant survival rates.

COMMENT

A classification of broad acceptance is necessary for any organ disease in order to properly evaluate incidence, symptoms, therapy and survival due to this disease. The classification of testicular tumors according to the scheme of Dixon and Moore[3] undoubtedly has found the widest acceptance. It is used almost universally in current reports, and therefore was used in the description of the testicular tumors in this series.

The benign tumors shown in Figure 1 consist actually of only two categories. Five of the 7 cases were adenomatoid tumors, also classified as mesothelioma. Clinically these tumors are rather uniformly slow growing and of small size. In spite of the variable histological structural pattern seen in different cases this tumor is quite benign (Fig. 5). Two were the rare specialized gonadal stromal tumors. Since they arise from the specialized stroma of the primitive gonad (Fig. 6), proper classification often is very difficult. They have been

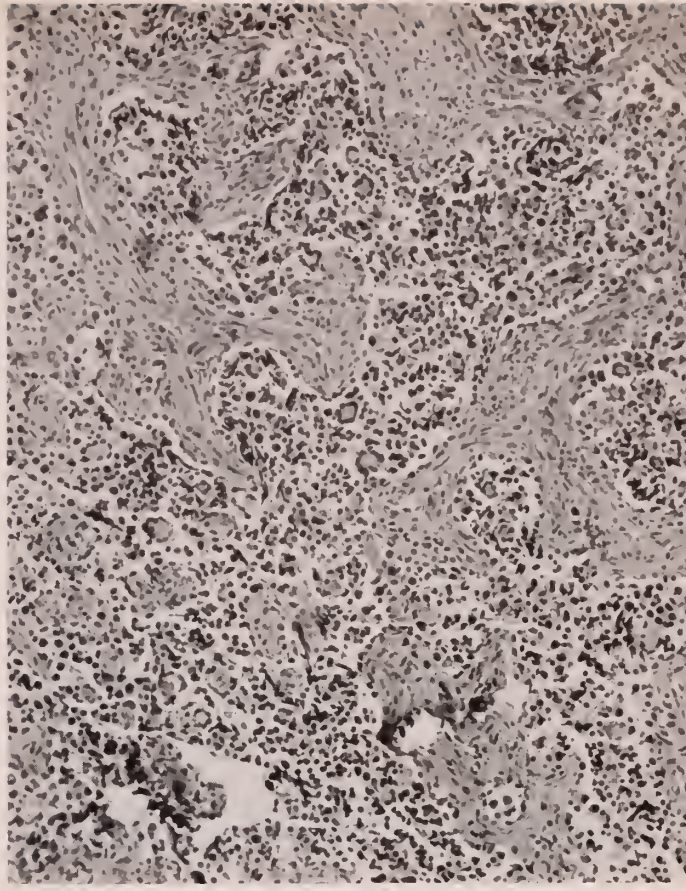
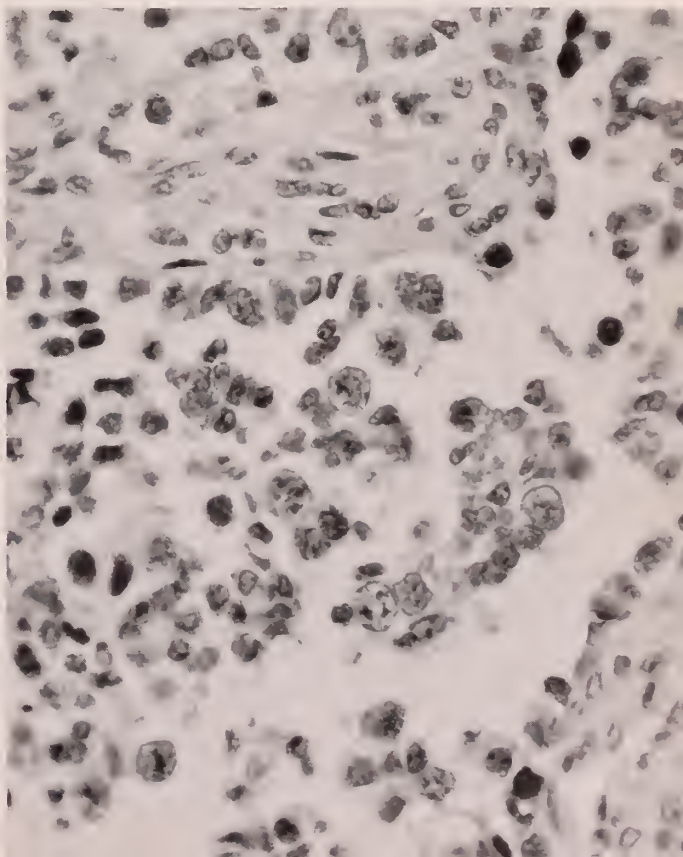


Fig. 3—View of a seminomo in a nine-year-old boy. Prominent fibrous septoe separate cells into clusters (X250). (Reprinted with permission of *The Jaurnal af Uralagy*, Vol. 87:710–714 [May] 1962)

Fig. 4—View of the same seminamo as in Figure 3. Large cells with vesiculor nuclei are germ cells ond small dork cells ore of the sex cord type (x500). (Reprinted with permission af *The Journol of Urology*, Vol. 87:710–714 [Moy] 1962)



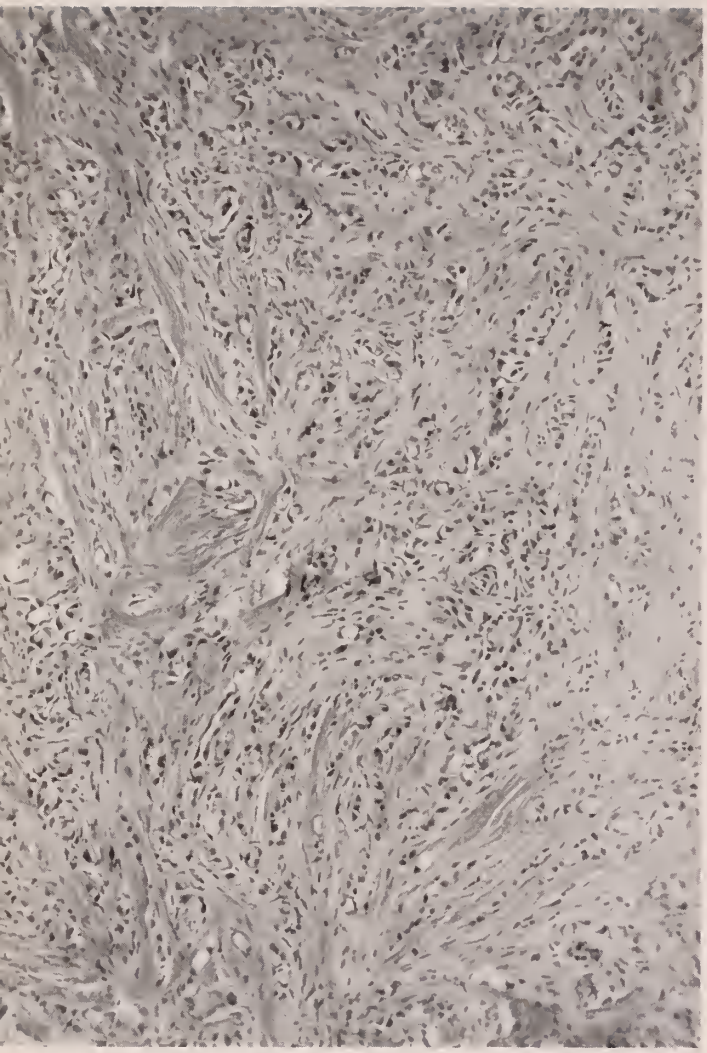


Fig. 5—Vascular channels and compressed cords within a dense fibrous stroma compose the typical adenomatoid tumor (X250).

variously designated as Sertoli cell tumor, androblastoma, and granulosa cell tumor of the testes.

The results and figures show that among the malignant tumors there were 14 seminomas, 6 embryonal carcinomas, 4 teratomas, 4 choriocarcinomas and 2 lymphomas. The seminomas are the most common malignant tumors comprising 30 to 40 per cent of the various series,[3,5,7] and occur in a relatively older age group. They comprise 48 per cent of the malignant tumors in our series, and the age group in which they occurred was similar to that in other studies. Embryonal carcinomas, less frequent than seminomas, account for 20 to 30 per cent of all malignant tumors and occur in the 20 to 30-year-old-age group.[3,7,8] The incidence of embryonal carcinoma in our series was 20 per cent. Teratomas occur in about 10 per cent[3,7,8] of the testicular tumors in adults, but the relative incidence in children is higher. The number of teratomas and choriocarcinomas in our series was too small to compare with any large series.

Testicular tumors in Negroes are rare and none occurred in our group. Two recent studies,[2,6] one of which was from a hospital with a large number of Negro admissions, had a total of 7 cases of testicular tumors occurring in Negroes, all in cryptorchid testes.

The results in Table 1 show that 80 per cent had swelling of the testis, 36 per cent had pain, 13 per cent were associated with hernia and hydrocele and 10 per cent had associated cryptorchidism. The usual primary symptom leading to the diagnosis of testicular tumors is the change in size and consistency of the testicle.[2,3] In addition there may be aching pain in the testicle and groin as depicted in this figure. Some authorities[3,9] suggest that pain associated with swelling has an adverse effect on mortality. If metastasis is present, high lumbar pain or cough with hemoptysis may be the presenting symptoms. The incidence of associated hernia or hydrocele, 13 per cent in our series, compares favorably with others. On physical examination one has to differentiate between hydrocele, hematocele and epididymitis. Considering the relatively simple approach and the accessibility of the tumor, it is surprising that many of these people are incorrectly diagnosed as having a non-neoplastic lesion. Thompson and his colleagues[6] reported this feature occurring in 30 per cent of the patients that had been admitted primarily because of testicular lesions. One can easily be misled when epididymitis is suspected and further examination reveals pus in the prostatic secretions.

Since a testicle cannot be satisfactorily examined if it is surrounded by a large amount of fluid, a hydrocele must be aspirated before a diagnosis can be made. Further diagnostic aids are an x-ray film of the chest which would rule out pulmonary metastasis, and an intravenous urogram may disclose enlarged retroperitoneal lymph nodes. A 24-hour urine specimen should be

collected for determination of gonadotropic hormones which would indicate the presence of trophoblastic tissue, and subsequent tests will then be of help in assessing the effectiveness of therapy. Unfortunately many of the seminoma cases will not have an elevation of the gonadotropin levels.[10] Not all of our patients had hormone assays. However, one of them had an initial reading of 50,000 units on admission and after orchidectomy there were no units reported. Two months later he developed a cough. An x-ray film of the chest showed pulmonary metastasis. A further assay showed urinary gonadotropin levels of 30,000 units. Another case of choriocarcinoma on a subsequent admission had a 24-hour secretion of over 1,000,000 units in the presence of demonstrable pulmonary metastasis.

The survival statistics are a true image of the effectiveness of the therapy carried out. Considering that there were a number of physicians attending the patients in our series, we found a surprising agreement in the therapeutic approach to the problem. The treatment of testicular tumors depends considerably upon their composition, thus necessitating prompt removal upon discovering the lesion. All the seminomas in our series were treated by an orchidectomy followed by irradiation, with an 8 per cent mortality which compares to 10 per cent in other studies.[1,7,8] In most studies death from testicular neoplasms occurred within 2 years and this has led some authors[7,9] to conclude that a 2-year survival constitutes a good prognostic index for 90 to 95 per cent of the tumor cases. Our series of embryonal carcinoma and teratoma cannot compare with national figures, but it is significant that only 1 of each group died and death occurred within 1 year after making the diagnosis. Other reported studies[1,4,7,8] show that 60 per cent of the patients with embryonal carcinomas will be dead within 2 years, and teratomas are associated with a 52.2 per cent mortality in a 5-year period. In the experience of the Armed Forces Institute of Pathology,[4] patients with lymphosarcoma usually die with generalized spread within 2 years.

It is recognized that the natural history of testicular tumor varies widely. Experience has shown that there is a high incidence of lymphatic spread which is often clinically undemonstrable, and for this

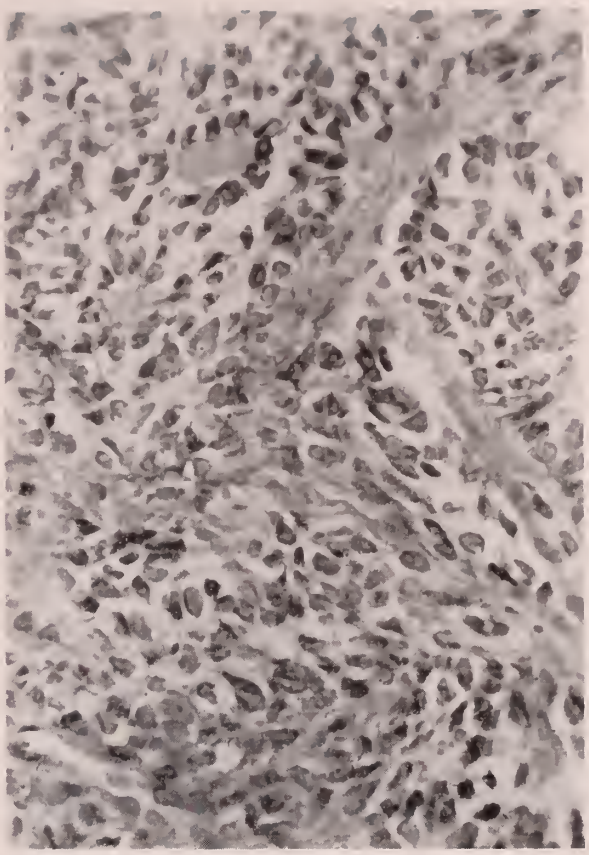


Fig. 6—Tumar of specialized ganadal strama made up af Leydig cells and Sertali cells (X500).

reason treatment of the regional lymphatics is recommended. A difference of opinion exists regarding the treatment of regional lymphatics of the respective tumor types. The therapeutic value of irradiation has been demonstrated by markedly increased survival rates, but not all testicular tumors are equally radiosensitive.[11] Operations in selected cases have shown marked additional value and the experience of the Armed Forces and others has shown that cases of embryonal carcinoma and teratoma had increased survival rates with surgical lymph node resection. It is generally agreed that in operating upon the retroperitoneal lymphatics a clean and thorough dissection from the diaphragm to the pelvis must be carried out.

At present the accepted therapeutic approach is removal of the tumor whether or not metastasis is present. After the microscopic diagnosis is made, further treatment can be instituted. Seminomas rank among the most radiosensitive, the lethal tumor dose being about 2,000 r. Hence, seminoma

should always be given prophylactic radiation. If the tumor is not mixed, this treatment will suffice. Embryonal carcinomas and carcinomatous elements of teratocarcinomas are much more radioresistant. The mean lethal dose for either tumor is probably over 5,000 r. Patients with these tumors should have radical lymph node resection followed by irradiation to this site. Up to the present time there has been no satisfactory treatment for choriocarcinomas, because they are radioresistant and spread early via the blood stream. Dr. Fred Ansfield,[12] professor at the Tumor Clinic, University of Wisconsin, stated that the combination of actinomycin D, 4-amino-N10-methyl-pteroylglutamic acid (Methotrexate) and 4-{p-[Bis(2-chloroethyl) amino] phenyl} butyric acid (Chlorambucil) as chemotherapeutic agents has given encouraging results in all testicular tumors other than seminoma. Two of our patients with choriocarcinoma were treated by Doctor Ansfield upon the appearance of pulmonary metastasis after orchidectomy. Both showed striking resolution of the pulmonary lesions and one is still alive pursuing his occupation in apparent well-being 10 months after the diagnosis was made.

SUMMARY

A series of 37 testicular tumors in patients treated in a 350-bed general hospital over a 10-year period has been reviewed. Incidence of tumor type as well as age of occurrence and the frequency of pertinent symptoms has been compared with other studies. Follow-up studies were available on on all patients and the survival rates for the various tumor types compared. The diagnosis and treatment of testicular tumors was also reported.

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HEADACHE THERAPY

Condensed from Roche Report on Medical Progress, August 7, 1961.

Preliminary studies indicate that a new serotonin antagonist, methylsergide, markedly prevents some types of chronic migraine headache. In a controlled study which now involves more than 300 patients at Montefiore Hospital Headache Unit in New York City, improvement has been registered in 68 per cent of those taking methylsergide, Dr. Arnold P. Friedman reports. However, the new drug is not effective in the symptomatic treatment of migraine headache. Among the 68 per cent of the patients who showed improvement, some were symptom free, while some had less frequent and less severe attacks. Prophylactic use has now continued in some cases for up to 14 months.

Recent evidence suggests that methylsergide, in addition to its central and anti-inflammatory properties of a nonspecific nature, may secondarily induce vasoconstriction. The drug is given in doses of 2 mg. tablets, three to six times a day. Although in most cases side effects have been minimal, the drug is given after eating to avoid nausea and the dosage is gradually built up. Other side effects that have been noted in a few patients include dizziness, feeling of unreality and leg cramps. The intermittent claudication and other peripheral vascular problems—noted in 3 patients in Dr. Friedman's series—would indicate that the patient under methylsergide therapy must be carefully observed by the physician. Calling the new agent "interesting and provocative," Dr. Friedman said that among the 400 odd remedies proposed for migraine, methylsergide appears to be the most effective prophylactic drug found thus far.—INTERNATIONAL MEDICAL DIGEST, Vol. 78, No. 6.

Treatment of the Incompetent Cervix to Prevent Second Trimester Abortions

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and STEPHEN D. AUSTIN, M. D.
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THE INCOMPETENT cervix syndrome is due to a mechanical defect of the cervix which renders it inadequate to withstand the increasing intrauterine pressure of pregnancy, resulting in relatively painless second trimester abortions or early premature labor. This syndrome has been known for many years, but that it was due to a mechanical cervical defect was first recognized by A. F. Lash in 1941. In 1950, Lash reported seven cases of cervical incompetence corrected by anterior trachelorrhaphy.[1] The first purse string repair was performed by McDonald of Melbourne in 1951,[2] but was initially described in the literature by Shirodkar of Calcutta in 1954.[3] In this country the Shirodkar procedure has been endorsed and modified by Barter,[4] Durfee,[5] and Picot.[6] Currently this procedure is performed in most communities offering modern obstetrical care.

CAUSE

Many patients with cervical incompetence will give a history of previous obstetrical or surgical trauma. Overzealous cervical dilatation, violent or precipitate birth, operative delivery, Duhrssen's incisions[7] and cervical amputation[8] have all been mentioned as causative factors. In other cases a definite traumatic history is unobtainable, and it is felt that a congenital weakness may render the cervix incompetent to withstand the increasing pressure of pregnancy.[6] In some of our cases a definite traumatic procedure has preceded the appearance of cervical incompetency while in others no such history was obtained. The incompetent cervix is an uncommon problem and has been estimated to occur 3 times per 1,000 deliveries.[6]

DIAGNOSIS

The diagnosis depends upon two main points: (1) the history of painless second trimester abortions; and (2) the demonstration of a defect in the cervix. A history of a previous traumatic procedure may also alert one to the possibility of an imcompetent cervix.

Presented at the annual meeting of the Wisconsin Society of Obstetrics and Gynecology, October 21, 1961, Madison.

The second trimester abortions are usually characterized by vague pelvic heaviness, followed by sudden rupture of the membranes and a short painless labor. In some cases herniation of the dependant portion of the bag of waters may initiate labor followed thereafter by rupture of the bag of waters. Other causes of second trimester abortions should be eliminated when evaluating information suggestive of cervical incompetence. These would include uterine congenital abnormalities, placental separation, infection, intrauterine death, and uterine fibroids.

Various procedures have been suggested for demonstration of the cervical defect. In the nonpregnant state, the passage of a No. 7 or 8 Hegar dilator through the cervical canal with very little resistance is suggestive evidence of cervical incompetence. A radiographic technique using balloons has been described by Rubovits.[7] In the immediately aborted patient, palpation may reveal the defective area in the anterior or lateral portion of the cervix. In the pregnant patient, demonstration of the defect depends upon detection of progressive painless effacement and dilatation. This may occur relatively suddenly and hence weekly cervical examinations are performed after the third month.

In the final analysis, both a suggestive history and a demonstrable defect are required to establish the diagnosis. Some patients with a suggestive history will not have a demonstrable defect and will carry subsequent pregnancies to term. Other patients having no history of second trimester abortions but a demonstrable defect may also carry to term without difficulty.

OPERATIVE PROCEDURES

Anterior trachelorrhaphy and purse string reinforcement are the main operative procedures used in correction of cervical incompetence. Each has its advantages and disadvantages. The Lash procedure offers the best anatomical repair but cannot be performed during pregnancy. We consider this a definite disadvantage since in many cases, the diagnosis of cervical incompetence cannot be established until painless dilatation occurs during pregnancy. The purse string corrective procedures may be performed in the pregnant as well as the nonpregnant state. A disadvantage of purse string procedures is the necessity of abdominal delivery, especially if future pregnancies are anticipated. Following the Lash procedure, vaginal delivery is possible if the presenting part is fixed in the pelvis at the time of onset of labor.[9]

Lash believes the opportune time for anterior trachelorrhaphy is at midcycle or immediately following an abortion.[9]

OPERATIVE TECHNIQUES

In anterior trachelorrhaphy[7] the bladder is dissected from the anterior surface of the cervix and the defect located by palpation. The entire defective area is excised and the wound closed with two layers of interrupted No. 2 chromic catgut. The vaginal incision is closed with interrupted catgut suture.

In performing the purse string operation[3] we use a Dacron flat strip specifically designed for this operation. The bladder is dissected from the anterior surface of the cervix. A small incision is made in the posterior fornix and the Dacron material is guided around the cervix submucosally with the aid of aneurysm needles. In instances where the cervix is dilated to 4 to 5 cm. at the time of repair, it may be necessary to make small vaginal incisions at three and nine o'clock to facilitate encircling the cervix. If aneurysm needles are not available, hemostats may be used to guide the material around the cervix. The Dacron material is inserted as high as possible about the cervix and secured by using a one loop knot and suturing the ends to the encircling portion of the Dacron material. This avoids a bulky knot which may erode through the mucosa, thus predisposing to infection. The strip is fixed anteriorly and posteriorly to the cervix with 2–0 silk suture to prevent downward slippage.

Following the purse string repair performed during pregnancy, bed rest is advised for three to four days with dismissal from the hospital occurring on the fourth or fifth postoperative day. Antibiotics are administered both vaginally and sytemically to combat infection.

CONTRAINDICATIONS TO REPAIR

With careful selection of patients one can expect a 70 to 80 per cent success rate regardless of the type of procedure performed. Unfavorable factors representing definite contraindications to repair are amnionitis, labor, rupture of the membranes, dilatation beyond 5 cm., and premature separation of the placenta.

Complications of cervical reinforcement leading to unfavorable results are infection, rupture of the membranes, and the onset of labor with possible uterine rupture.

CASE REPORTS

Case 1—A 31-year-old gravida VII, para IV, was first seen on May 28, 1959, with a history of having had her last menstrual period on March 24, 1959. A diagnosis of early pregnancy was made and the following pregnancy history obtained.

In 1951 an assisted breech delivery of a 2,950 gm. infant followed a 5-hour labor. In 1953 induction of labor was performed at 34 weeks because of antepartum hemorrhage. A healthy 2,050 gm. infant was delivered spontaneously. In 1954, at 30 weeks gestation, spontaneous delivery of a 1,100 gm. infant followed a labor lasting four hours. The infant died a few hours after birth. In 1955 a 700 gm. infant was delivered after a painless labor of one and one-half hours. In 1956 a spontaneous abortion occurred at two and one-half months. In 1957 a mid-trimester abortion occurred at four and one-half months while the patient was enroute to the hospital.

After the third month of the present pregnancy, weekly cervical examinations were performed and progressive effacement and dilatation were detected at the twenty-sixth week. The patient was hospitalized and scheduled for a Shirodkar cervical repair the following morning. At the time of the repair the cervix was completely effaced and the membranes were bulging through a 3 cm. dilated cervix.

The patient had an uneventful course following the repair and was discharged on the fifth postoperative day. The remainder of her prenatal course was uneventful, and a low cervical Cesarean section at the thirty-eighth week resulted in the birth of a healthy 2,875 gm. male infant. The postoperative course was again uneventful and the patient and her baby were discharged on the sixth postoperative day.

Case 2—A 40-year-old gravida IX, para II, had a poor obstetrical history. Her first pregnancy in 1941 resulted in delivery of a 3,180 gm. infant after two hours of labor. In 1941 and 1942 she had spontaneous abortions, each at three months. In 1954, 1955 and 1956 she had spontaneous painless abortions, all five to six months gestation. In January, 1958, she noted premature rupture of the membranes and labor at 33 weeks, resulting in delivery of a 2,420 gm. infant which died from atelectasis. In August, 1958, she had a spontaneous abortion at two and one-half months.

A Shirodkar purse string repair was performed at 18 weeks gestation. The remainder of her pregnancy was uneventful and a low cervical Cesarean section at 39 weeks resulted in the birth of a 4,080 gm. infant.

This patient has subsequently been delivered of a 3,450 gm. infant by repeat Cesarean section.

Case 3—A 33-year-old gravida VI, para 0, was seen in June, 1960, because of a missed menstrual period. All five previous pregnancies had terminated in spontaneous abortions between three and three and one-half months gestation. The patient was first seen by us at the time of her fifth abortion. Examination at that time revealed a large defect in the posterior aspect of her cervix, extending from just proximal to the external os up to the internal os region at the cervicovaginal junction. The products of conception had been passed through this cervicovaginal fistula. The external os at that time was closed but not stenosed.

The cervicovaginal fistula was repaired during the sixth week of the present pregnancy by excising the margins including the external os region and then closing in two layers with interrupted O chromic catgut suture. Spinal anesthesia and the knee-chest position were used to facilitate exposure of the posterior aspect of the cervix. The postoperative period and remainder of the pregnancy were uneventful. A healthy 2,875 gm. female infant was delivered at term by low cervical Cesarean section.

Case 4—A 20-year-old gravida IV, para II, ab. 1, was referred to us on October 19, 1960, for maternity care. Her first pregnancy ended in spontaneous delivery of a 3,040 gm. living infant after an uneventful labor lasting four hours. In March, 1959, a spontaneous painless abortion occurred at 27 weeks gestation. In January, 1960, at 32 weeks gestation, spontaneous rupture of the membranes occurred, followed by the onset of premature labor and delivery of a 2,140 gm. infant. The labor was described as painless and of three hours duration. The infant died two and one-half days following birth.

Weekly cervical examinations were performed after the sixteenth week. The internal os remained tightly closed until the twenty-sixth week when it admitted a "finger tip." One week later the cervix was partially effaced and 3 cm. dilated.

A Shirodkar purse string repair was performed without difficulty, but unfortunately the patient went into active labor a few hours later. Vaginal examinations revealed bulging of the lower uterine segment in the anterior and posterior fornices during contractions. Following release of the mersiline strip, the cervix was 7 cm. dilated. The uterine contractions were then augmented with dilute Pitocin intravenously to expedite delivery while the patient was still anesthetized. A few minutes later spontaneous delivery of a 675 gm. infant occurred.

Manual removal of the placenta and exploration of the uterine cavity were carried out. A Lash anterior trachelorrhaphy was then performed without difficulty. The postoperative course was uneventful and the patient was discharged on the fourth postoperative day.

This patient is currently three months pregnant and will be carefully observed for cervical dilatation.

RESULTS

We have performed cervical reinforcing operations on 10 patients. One patient, too recently operated on for evaluation, is not included in this report. Table 1 summarizes results obtained in the other 9. Prior to cor-

TABLE 1—*Results of Treatment*

Patient	Prior to Correction		After Correction	
	Total Pregnancies	Living Children	Total Pregnancies	Living Children
G. P.	6	2	1	1
L. S.	5	2	1	1
R. H.	8	1	2	2
B. F.	4	2	1	1
L. S.	5	0	1	1
J. S.	2	0	1	1
M. S.	2	0	1	0
D. M.	3	1	1	0
P. L.	6	1	1	1
TOTALS	41	9 (22%)	10	8 (80%)

rective procedures, 9 patients obtained a total of 9 living children from 41 pregnancies, for a salvage rate of 22 per cent. Three of these 9 children were premature by weight.

Following corrective procedures, 10 pregnancies in the 9 patients produced 8 living children for a salvage rate of 80 per cent. One failure resulted when labor began at 24 weeks in a patient who had a prepregnant repair. The second failure is reported in detail in Case 4.

COMMENT

There is now general agreement that cervical incompetence is a definite causative factor in some late abortions. There continues to be some disagreement on criteria for diagnosis, optimum time of repair, type of corrective procedures, and management of delivery subsequent to cervical reinforcement. Our own experience, although not extensive, stimulates us to make some observations on these controversial points.

Relative to criteria for diagnosis, we feel that the most reliable diagnostic feature is progressive effacement and dilatation during the second trimester. This is contrary to Picot who believes it "unnecessary and undesirable to wait until the cervix is dilated and the membranes visible."[6] Our disagreement to this philosophy stems from the fact that some patients with a typical history will carry to term without repair. It is true that the prognosis for a successful repair is better if done before dilatation occurs, but some repairs will be performed unnecessarily if strict adherences to diagnostic criteria are not maintained. Illustrative of this point is one of Picot's patients[10] operated at 26½ weeks with removal of the suture strip a few hours postoperatively because of uterine irritability and subsequent delivery at 37 weeks gestation. Case 4 represents a failure in a patient operated at 26 weeks with cervical dilatation to 3 cm.

Uterine irritability a few hours following repair is a common occurrence and difficult to differentiate from true premature labor. Vaginal examination during a true labor contraction will reveal bulging in the anterior and posterior fornices proximal to the sutures. If this continues, the suture material must be removed to preclude uterine rupture. If the uterine irritability is not accompanied by the bulging in the fornices, the patient may be observed until uterine quiescence occurs.

We have favored the Shirodkar operation over the Lash procedure primarily because the diagnosis in most of our cases has been made during pregnancy. In the immediately aborted patient, the Lash procedure offers the advantages of ease of performance and the convenience of carrying out the repair during the period of hospitalization for the abortion.

We favor delivery by Cesarean section in patients having had a Shirodkar cervical reinforcement operation, primarily to protect the successful repair for subsequent pregnancies. If a patient has no desire for more children, the suture material may be removed at term and vaginal delivery carried out.

Case 3 represents incompetence resulting from a large fistula extending from the external to the internal os region. Prior to repair, all five previous pregnancies had terminated in spontaneous abortions at three to three and one-half months. With reinforcement of the internal os region and repair of the fistula, the patient was able to carry to term. The etiology of the fistula is obscure.

SUMMARY

Cervical incompetence is a definite causative factor in some late abortions. The diagnosis of cervical incompetence depends upon the history of painless second trimester abortions and the demonstration of a defect in the cervix. In the pregnant patient, demonstration of the defect depends upon detection of progressive effacement and dilatation by weekly cervical examinations. Prior to corrective procedures, 9 patients obtained a total of 9 living children from 41

pregnancies, for a salvage rate of 22 per cent. Following corrective procedures, 10 pregnancies in the 9 patients produced 8 living children for a salvage rate of 80 per cent.

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Frog Pregnancy Test

TIME TO RUN THE TEST

Chorionic gonadotropin appears in the blood stream and urine of pregnant women between the *40th and 50th days* after the date of the onset of the last menstrual period, and it is this hormone which causes the release of sperm in the male frog's urinary bladder. The frog's urine, checked microscopically, is then the determining factor in diagnosis of pregnancy; in other words, the presence or absence of sperm constitutes a positive or negative test as the case may be. Urine or serum of most pregnant women produces a positive response by the *40th day*. However, a negative result should not be considered conclusive prior to the *60th day*. Therefore, if clinical indications of pregnancy exist, the test should be repeated in a week. The test is invalid after the first trimester.

SPECIMEN REQUIRED

Urine: The use of random urine is not recommended since *fasting morning urine* has been found to be far more satisfactory. This specimen contains a higher concentration of chorionic gonadotropin. A fasting urine is the first urine voided in the morning following abstinence of the subject from food or drink after 9 p. m. the night before the test. When fasting a. m. urine is used, the *specific gravity* should be at least 1.010.

Serum: Of late, the use of blood serum instead of urine has become standard in many laboratories. An advantage in the use of serum is the apparently earlier presence of gonadotropin and in greater quantities. We are not faced with the toxic manifestations that are encountered from time to time in urine samples. Also, serum specimens can be obtained at any time during the day.

From Department of Laboratories, Mercy Hospital, Janesville.

IMPORTANCE OF THE TEST

1. The test is valuable in the early diagnosis of pregnancy, with over 99% accuracy including ectopic pregnancy.
2. If the frog test is negative and other signs of pregnancy persist after the 60th day, a pathological condition should be suspected.
3. The frog test may be of considerable value in cases of uterine bleeding due to abortion. As long as live placental tissue is implanted in the uterine wall, the test will remain positive. In patients with vaginal bleeding, if the frog test has been positive and then becomes negative within a short time, abortion may be suspected.
4. The simplicity of the test and its low cost allow repeated tests at periodic intervals in patients following evacuation of hydatidiform moles. It is recommended that such a patient be advised to avoid pregnancy and that the test be performed at monthly intervals for six months.
5. The frog test is also of value as a routine preoperative test. The most astute diagnostician may not discover early pregnancy until the time of laparotomy. A routine preoperative frog test will usually eliminate such errors in diagnosis.

DO YOU KNOW ?

New York City's Board of Health has banned all tattooing in the city except for medicinal purposes, reporting that since mid-1959, 30 cases of serum hepatitis and one death have been traced to tattooing.

CLINICOPATHOLOGIC CONFERENCE

Sponsored by Section on Pathology
State Medical Society of Wisconsin

Guest Editor: ROBERT S. HAUKOHL, M. D.
Milwaukee, Wisconsin

CASE PRESENTATION*

A 79-year-old white man was initially hospitalized in 1956 for anemia of undetermined cause. A complete examination, including gastrointestinal x-ray studies, was nonrevealing. The patient was admitted to this hospital for the first time in February, 1957, with a complaint of lumbar pain. He was treated with conjugated estrogens (Premarin) and testosterone and discharged after five days. He reentered the hospital June 24, 1958, with a six-month history of progressive weakness, chest pain, effort breathlessness, and a cough productive of yellowish sputum. He had lost 20 pounds in weight over a two-month period preceding this admission. Additional history revealed only overflow urinary incontinence. Family and past history otherwise were noncontributory.

The patient's blood pressure was 120/60, temperature 99.6 F., pulse 88, and respirations 20. He appeared chronically ill, with marked pallor, moderate dyspnea and mental confusion. Coarse moist rales were heard over the right lung base. Rectal examination showed Grade 2 enlargement of the prostate gland. No other positive physical findings were noted.

A roentgenographic examination at the time of his first admission to this hospital in February, 1957, showed: chest—emphysema, abnormal aorta and scoliosis; lumbosacral spine—extensive demineralization and lumbar scoliosis, with compression of varying degrees of all the lumbar bodies; excretory urogram—bifid pelvis and proximal three-quarters of ureter on the left side.

A similar examination at the time of his second admission to this hospital in June, 1958, revealed: chest—bilateral apical pleural thickening, with diffuse accentuation of the bronchovascular markings and fine nodularity in the lower lung fields bilaterally, widening and calcification of the aortic arch and transverse diameter of the heart increased to 15.5 cm.

Laboratory examination in February, 1957, showed an erythrocyte sedimentation rate of 88 mm. in one hour, hemoglobin level of 10.2 gm. per 100 ml., hematocrit reading of 31%, white blood cell count of 5,000 with a differential of 50 lymphocytes and 50 segmented neutrophils. Urinalysis was negative; blood glucose, 135 mg. per 100 ml.; acid phosphatase, 0.05 units. An electrocardiogram was read as abnormal on the basis of a first degree atrioventricular block.

In June, 1958, the erythrocyte sedimentation rate was 129 mm. in one hour, hemoglobin level was 7.5 gm. per 100 ml., hematocrit reading 27%, red blood cell count 2,000,000, white blood cell count 1,800 with a differential of 26 lymphocytes, 72 segmented neutrophils, 1 band form, and 1 monocyte. There was 1.1% reticulocytes. Urinalysis revealed a specific gravity of 1.023, 1 + albuminuria, negative Bence-Jones protein. Blood glucose was 120 mg. per 100 ml. and nonprotein nitrogen was 37.3 mg. per 100 ml. There were 3.6 Bodansky units of alkaline phosphatase, 0.28 units of acid phosphatase and no prostatic acid phosphatase. Calcium was 10.5 mg. per 100 ml., total protein, 3.8 gm. per 100 ml., with 2.25 gm. albumin and 1.55 gm. globulin. Serum protein electrophoresis showed hypoproteinemia due to decreased albumin; globulin distribution was normal. A stool specimen was negative for occult blood. An electrocardiogram showed nonspecific T-wave inversion in V2 and V3. Blood studies after transfusions showed a hemoglobin level of 11.6 gm. per 100 ml., hematocrit reading of 32%, white blood cell count of 1,150 with a differential of 20 lymphocytes, 71 segmented neutrophils and 9 band forms.

In July, 1958, at the time of his terminal admission, the patient's hemoglobin level was 12 gm. per 100 ml., hematocrit reading

*From Deaconess Hospital, Milwaukee.

26%, white blood cell count 550 with a differential of 35 lymphocytes, 45 segmented neutrophils, 15 bands forms and 5 monocytes.

While in the hospital, the patient complained of weakness, poor appetite, and occasional cramping lower abdominal pain. Temperature elevation was most prominent in the morning, ranging from 100 to 100.6 F. Sternal marrow, aspirated on June 25, showed senile fatty atrophy. Repeat aspiration from the iliac crest was interpreted by the pathologist as showing senile fatty atrophy, and by a consulting hematologist as showing multiple myeloma.

The patient was given prednisone (Meticorten) and received four units of red cell mass. His temperature became normal the day after prednisone therapy was begun. He was discharged in an improved condition on July 5, 1958. He was readmitted for the third time 20 days later in an unconscious condition.

History obtained from a son indicated that the patient had not eaten for a week and had been only semiconscious for five days. Blood pressure was unobtainable. A rapid, but regular, thready pulse rate was 120 mm. in one minute. There was marked dehydration, and a decubitus ulcer was present over the coccyx. Moist rales were heard over the left lung base. Rectal examination showed prostatic enlargement and "fecal impaction." The patient died approximately nine hours after admission.

CLINICAL DISCUSSION

Dr. Albino L. Settimi: Perhaps the most striking features of this interesting case are the hematological aberrations. The principal changes from normal are those which appeared terminally. It is noted in the protocol, however, that the patient initially had an anemia which was discovered and treated in 1956. Therapy apparently was directed toward the osteoporosis which, while not reported on x-ray studies at that time, was demonstrated in 1958. It was probably the cause of the lumbar pain which was mentioned as early as 1956.

It might be mentioned parenthetically that in recent years testosterone has been used as an erythropoietic substance in various types of anemia, even including aplastic anemia, with some occasional rather outstanding results. The actual mode of action is apparently still unclear, but probably there is an acceleration of the rate of cellular production at the stem cell level.

The chest x-ray films do not particularly help me in the diagnosis. It is apparent that there is no evidence in this patient of a thymoma, which on occasion has been reported to cause anemia and pancytopenia.

The real clue to the correct analysis of this case revolves about a decision as to whether the hematological changes are primary; that is, due to a primary blood disease, or whether they are actually secondary manifestations of some other disease process. The bone marrow interpretation of a fatty atrophy in itself has no particular meaning to me. However, a second bone marrow report is noted in the protocol as being perhaps compatible with myeloma, and this is of some interest. The actual differentiation between a plasmacytosis and a myelomatosis is rather difficult in certain cases, and particularly here where there apparently is a rather focal distribution of plasma-type cells and in a presumably hypocellular marrow. No note is made about the general appearance of the cells as to their apparent maturity. Recently an aid in the differentiation between the two states has been an expression of the nucleolar-nuclear ratio, the ratio generally being lower in plasmacytosis. The electrophoretic pattern does not support the impression of a multiple myeloma.

Primary marrow disease in the form of agranulocytosis must be considered. In the peripheral blood the presence of certain cellular precursors rather than an actual hiatus would seem to indicate that a true agranulocytosis of the marrow did not exist. There is a rather marked shift of the neutrophils to the left. Neutropenia regularly occurs in almost all of the megaloblastic anemias, and I believe an estimate of the mean corpuscular volume in this individual would indicate that the anemia is macrocytic in type. However, I doubt that this is a cause of the demise of this patient.

There is no history of drugs capable of inducing these particular hematological changes, nor is there history of radiation in the past. However, the patient is noted to be cachectic and this very frequently will also cause neutropenia.

It is quite well known that leukopenia is commonly found in various types of in-

fections, particularly in the virus diseases in the absence of complications. There are certain protozoan infections which may likewise be implicated.

This particular hematological change has also been noted in overwhelming bacterial infections, some of those being of a chronic nature as well as the acute and subacute. Typhoid usually is accompanied by an actual lymphocytosis in the presence of a leukopenia. Perhaps the key to the situation is the fact that in the presence of this marked secondary leukopenia, this patient does have an absolute lymphocytopenia. This has been reported in the past in primary amyloidosis. However, the physical examination and the apparent lack of the amyloid material in the marrow would seem to exclude this possibility.

On the basis of the foregoing discussion, the persistent febrile course of the patient, the presumed secondary hematological changes in the peripheral blood and bone marrow, and the startling effect of prednisone on the patient's course—almost amounting to a resurrection—this patient in most likelihood had the condition described as typhobacillosis of Landouzy, more commonly known as chronic nonreactive tuberculosis. The effect of the prednisone was reminiscent of the final scene of La Boheme when Mimi, afflicted with consumption, was under the illusion that she had suddenly become well shortly before she died. Some years ago, Dr. A. Ahrens described in the *Acta Medica Scandinavia* several cases of nonreactive tuberculosis, one of which exhibited an almost exact parallel course. These hematological changes are not specific for tuberculosis, as many variable clinical signs have been described. The patient had an elevated blood sugar and presumably had diabetes. This would tend to increase the possibility of tuberculosis by at least tenfold. The condition may have also been considerably aggravated by the prednisone therapy.

A tuberculin test would probably have been of no value, as in this condition, as well as in the lymphomas, hypothyroidism, sarcoidosis, and occasionally in pregnancy, the tuberculin test is negative, apparently due to an anergy. The changes described on the electrocardiogram are nonspecific, and merely reflect myocardial degeneration on the basis of arteriosclerosis and perhaps brown atrophy of the heart.

PATHOLOGIC DISCUSSION

Dr. Robert S. Haukohl: Doctor Settimi is to be congratulated on his extremely perceptive and critical discussion. He is perfectly correct in concluding that this patient died of disseminated tuberculosis, with secondary hematological changes.

An autopsy was done approximately 10 hours after death. It revealed a well developed, but extremely emaciated elderly white man. The peritoneal surfaces were rather hyperemic and were studded with innumerable tiny pinhead-sized grayish-white nodules, on both the visceral and on the parietal surfaces. There were 1,000 ml. of slightly turbid yellowish-brown fluid in the abdominal cavity. The right lung was completely enveloped in a dense mass of fibrous adhesions. The left lung lay free. There was some scarring apparent in the right upper lobe, and the tracheobronchial lymph nodes were diffusely enlarged and moist. No significant changes were noted in the heart or major vessels except for a moderate to marked degree of arteriosclerosis. The spleen was of normal size and shape. It had a firm pulp. The malpighian follicles were rather prominent. The liver was of normal weight and configuration. The cut surface showed numerous, ill-defined, small irregular, dark red areas scattered throughout the parenchyma. The remaining lobular architecture was well defined.

There were no significant changes apparent in the genitourinary tract. The stomach displayed a large ulcerating mass completely encircling the antrum. This was rather flat, but measured 10 cm. in its greatest dimension, with a superficial ulcerated area 3.5 cm. in diameter. The cut surface revealed pale pinkish-yellow rubbery tissue. Although there was no apparent obstruction, the prepyloric region of the stomach was considerably reduced in caliber. The bone marrow was grossly normal.

At the time of the gross autopsy, we presumed that this patient had a primary carcinoma of the stomach, with peritoneal and probably bone marrow metastasis, and that this would satisfactorily explain the hematological picture. We were rather startled when studying the microscopic

sections prepared from this case to find tiny granulomata scattered throughout the body. These were particularly prominent in the serosa of the stomach and intestines, the spleen, the liver, in the bone marrow and in the lymph nodes. The patient also had infiltrating adenocarcinoma of the stomach, but no metastasis was demonstrated. Although granulomas were demonstrated in the marrow, the marrow picture was predominantly that of marked hypoplasia, with senile fatty atrophy. Multiple tiny foci of plasmacytic hyperplasia also were found. It is presumed that one of these was aspirated on one occasion and led to the erroneous presumption of multiple myeloma in this case. The granulomas in all situations showed characteristic acid-fast branching and beaded rods when stained with an appropriate technique. Unfortunately no material was saved for culture, but the histologic configuration of the granulomas, and the appearance of the organisms, were quite characteristic of Mycobacterium tuberculosis infection.

The association of tuberculosis and a variety of hematological syndromes has long been recognized. There is little consistency in the pattern of the hematological syndrome present. Credit should be given to Donhauser, who in 1908 described certain abnormalities in peripheral blood in cases of tuberculosis, and to Weichmann, who did the same in 1922. Because of the frequent association of leukemia and tuberculosis, at one time the German school of hematologists felt that miliary tuberculosis was one of the important causes of leukemia. In 1938, Engelbreth–Holm[1] reported four cases of hematological abnormality in tuberculosis. There was no consistency to the picture. One patient presented as typical pernicious anemia, another as acholuric jaundice, and a third as Banti's syndrome. The medical literature is replete with isolated case reports of the association of some peripheral blood abnormality in disseminated tuberculosis, usually tuberculosis of the miliary type. The peripheral blood manifestations may run the gamut of abnormalities. It requires an extremely astute clinician to deduce that tuberculosis is the underlying etiologic mechanism and to institute aggressive treatment. The hematological syndrome may show alterations of white blood cell count from aplasia to a leukemoid picture, and selective alterations of cells from a selective cytopenia to pancytopenia. It may or may not be associated with splenomegaly; there may or may not be demonstrable granulomas in the marrow. Anemia is almost universally present.

Regardless of the peripheral blood picture, all cases demonstrate a similar clinical picture—a picture that suggests an undiscovered malignancy or advanced tuberculosis. The patient is invariably febrile, complains of night sweats and profound weakness. This coupled with an unexplained hematological alteration, usually anemia with leukopenia or a leukemoid reaction, should stimulate the alert clinician to further investigation in the hope of identifying the etiologic mechanism. Even in the absence of positive identification of tuberculosis, some astute internists have begun aggressive antituberculosis therapy with beneficial results.

The mechanisms for the development of the hematological syndrome are uncertain. Two principal theories have been promulgated—the first of these related to abnormal splenic function and/or bone marrow release of cells. It is certain that on occasion this is the fundamental mechanism because of the presence not only of splenomegaly and thrombocytopenia, but that the patient showed remarkable improvement in the peripheral blood picture after splenectomy. However, this mechanism cannot be called upon to explain all of the other cases. The second principal theory relates to marrow invasion, replacement or necrosis associated with the tuberculous process. This may well be a factor in many cases, but certainly is not operative in the case presented here, since granulomas were difficult to find in the marrow. Medd and Hayhoe in 1955 refuted these two theories and reviewed most of the reported cases. They point out that frequently there was no splenomegaly or marrow invasion. They suggested that a hypersensitive mechanism might be operative, and that the reaction occurred primarily between the products of the tubercle bacillus and the hematopoietic system.

Perhaps better insight into the condition could be obtained from a review of the work of Doan and Sabin,[2] who in 1927 infected various laboratory animals with tubercle bacilli and serially studied the peripheral

blood and marrow. They found initially that the marrow displayed many miliary tubercles, and by the twentieth day Langhans giant cells and epithelioid cells encroached upon the hematopoietic tissue and fat. If the animal did not succumb to the infection at this time, in two or three months there appeared to be spontaneous healing of the marrow, associated with marrow element hyperplasia. Even though the animal might be dying of disseminated tuberculosis elsewhere in the body, the marrow actually was healing and eventually returned to normal morphologically. The peripheral blood changes corresponded to those seen in the marrow.

It would seem that this is a dynamic rather than a static disease process, and that one might see a patient in various phases of the disease. Under certain circumstances, early in the course of the disease, he might present a picture of myelophthisic anemia, with marrow replacement. Later on, because of secondary hyperplasia, he might well present the peripheral picture of leukemia or of a leukemoid reaction. Should his involvement be primarily splenic, he might present a picture of hypersplenism. Should a hypersensitive mechanism develop, the patient might display total aplasia of the marrow and a pancytopenia peripherally, even without demonstrable tubercles in the marrow. This case probably falls in the latter group. Our final diagnosis is miliary tuberculosis, with secondary pancytopenia and an incidental infiltrating adenocarcinoma of the stomach.

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LEUKEMIA IN MAN FOLLOWING EXPOSURE TO IONIZING RADIATION

A Summary of the Findings in Hiroshima and Nagasaki, and a Comparison with Other Human Experience

Brill, A. Bertrand, Tomonaga, Masanobu and Heyssel, Robert M., *Annals of Internal Medicine* 56:590 (April) 1962.

The authors report a summary of the studies of the incidence of leukemia in survivors of the atomic bombings of Hiroshima and Nagasaki, and compare the results with other reported series. The incidence of leukemia is significantly increased in the "proximally exposed" survivors in both cities. The incidence of leukemia is greatly increased in the survivors exposed under 1,500 M. from the center of the atomic blast. Beyond 2,000 M. the incidence in Hiroshima is not significantly greater than expected in Japan where leukemia rates are 20 to 30 cases per million persons per year. Data show that leukemia incidence in the closely exposed is significantly higher in persons who experienced acute radiation sickness than in those who did not. However, among the proximally exposed, the rates for both those with and without these symptoms are higher than the expected rate. The data which the authors present leaves little doubt that the incidence of leukemia is increased following exposure to mixed gamma and neutron radiation and that the response is dependent upon the dose. They feel that the findings from Japan agree well with reports on the spondylitics and the children with thymic enlargement treated with x-ray.

They conclude the following: (1) The risk of leukemia is increased in populations exposed to ionizing radiation at doses of 50 to 100 rad and above. Between 100 and 500 rad, the relation between dose and leukemia incidence is compatible with a linear model. (2) The data suggest that the risk of leukemia is increased at a rate of one to 2 cases per million population per year per rad. (3) The predelection of the various types of leukemia for specific age groups does not appear to be markedly altered. The rarity of chronic lymphocytic leukemia in Japan is reconfirmed. (4) The increased incidence of leukemia apparently starts about one to one and a half years following irradiation.

OBSTETRICAL NOTE

Dr. Clifford A. Grand, Ashland, Wisconsin, has reported the delivery of unusually large twins on August 31, 1962. The combined weight of the binovular male twins was 20 lbs., 1 oz. (9.10 Kg.). The mother attained a weight of 240 lbs. She was gravida seven, para six. The first boy, a vertex presentation, weighed 10 lbs. (4.54 Kg.). The second boy presented a left hand and was converted to a footling by version. He weighed 10 lbs., 1 oz. (4.56 Kg.). The post-partum course was uneventful.

—Medical Editor

Editor
H. F. HARDMAN, M. D., Marquette University

COMMENTS ON TREATMENT

Opiate Antagonist Drugs

By GRACE W. GRAY, Ph. D.
Milwaukee, Wiscansin

HIGHLY SPECIFIC drugs with which to combat the signs of opiate overdosage have been available for many years, but there is still far from complete agreement as to their entire range of usefulness, and as to the precise nature and significance of their effects. The remarkable properties of drugs in this class were first noted in 1915 by Pohl who reported that the N-allyl analogue of codeine could reverse opiate induced central nervous system depression in animals. This observation lay virtually buried in the literature until the early 1940's when Hart and McCawley and Unna independently published similar findings for the comparable morphine analogue. Once more a nonproductive period occurred and further reports on the opiate antagonists did not appear until the early 1950's, at which time both extensive laboratory studies and clinical trials heralded the era of intense interest in these drugs which continues to the present day.

A. CHEMICAL NATURE

All natural opiate analgesic drugs (and the available synthetic opiates as well) possess an N-methyl group as one of the important structural requirements for maximum activity. Substitution of other alkyl or aromatic groups for the methyl on the nitrogen results as a rule in reduced potency or complete abolition of analgesic and narcotic activity. However, if the substituted group is of the approximate length of a three carbon chain (e.g. propyl, allyl, propargyl, isobutyl, cyclopropylmethyl, etc.), the resulting compound exhibits not only greatly reduced narcotic analgesic activity but also acquires the new property of preventing or reversing the pharmacological effects of its N-methyl parent compound (or of any other opiate analgesic drug).

As the chemists have progressively simplified the complex 5-ring morphine molecule in their search for useful opiate substitutes, the N-allyl analogues of these newer synthetics have been prepared and tested for opiate antagonist activity. Compounds of the morphinan series (e.g. levorphanol [Levo Dromoran] may be considered to be 4-ring fragments of the morphine prototype, and the N-allyl analogue of levorphanol is a potent opiate antagonist. Compounds of the benzomorphan series (e.g. phenazocine [Prinadol]) may be construed as 3-ring fragments of morphine, and N-allyl analogues in this series likewise possess antagonist activity. However, 2-ring compounds such as those of the meperidine (Demerol) series have not yielded antagonist drugs when their N-allyl analogues were tested.

B. PHARMACOLOGICAL EFFECTS

The two opiate antagonist drugs commercially available for clinical use are nalorphine (Nalline) and levallorphan (Lorphan), the N-allyl analogues of morphine and levorphanol respectively. When administered parenterally in small doses to man or animals, these antagonists have demonstrated the capacity to block to some extent at least all of the observable pharmacological effects (both central and peripheral) of any opiate drug. They have no such specific action against members of other drug groups such as the inhalation anesthetic agents, barbiturates, tranquilizers, or antipyretic analgesics.

In individuals or animals chronically dosed with opiates, the antagonists have the remarkable property of unmasking the physical dependence which has occurred by precipitating very rapidly the signs of the acute withdrawal (abstinence) syndrome characteristic of the species in question.

When administered alone to nontolerant human subjects, small doses of the antagonists may exhibit little action or may produce a spectrum of very mild morphine-like effects (sedation, analgesia, respiratory depression, nausea, miosis, etc.), but may also cause considerable dysphoria and anxiety.

Neither significant tolerance development nor physical dependence has been found to result from administration of the antagonist drugs to man, though attempts at adequate study have been severely limited by the generally unpleasant psychic effects of the drugs at higher dosage levels.

C. THERAPEUTIC USES

The pharmacological profile of the opiate antagonists clearly predicates certain of their important clinical applications. The major therapeutic uses of these drugs are the treatment or prophylaxis of opiate-induced respiratory delay or depression in the newborn infant, the antidoting of effects of over-zealous preanesthetic medication with opiates, and the differential diagnosis and treatment of accidental opiate overdosage poisoning.

Considerably less agreement has existed as to the rationale for administration of opiate and antagonist mixtures in the hope of achieving analgesia with reduced or absent undesired side effects. Many studies have been undertaken to determine optimal molar or milligram ratios of opiate to antagonist in such mixtures, and the early enthusiasm has given way to a general consensus that such mixtures cannot be demonstrated to achieve any desirable purpose in most clinical situations.

Still under intensive investigation is the possibility that antagonist drugs alone, when properly employed in selected situations, may serve as useful analgesic drugs which lack the excessive depressant effect and the addiction liability of their parent compounds. Nalorphine has been employed in some sections of this country as an adjunct to the legal management of narcotic addiction. Postaddicts in these areas have been required to report monthly for a "Nalline test" to discourage resumption of the use of opiates. An increase in pupil diameter in response to nalorphine is the criterion employed to detect opiate usage (whereas the appearance of signs of the acute abstinence syndrome, though not hoped for, would incriminate readdiction).

D. MODE OF ACTION

Evidence from a wide variety of pharmacological studies provides support for the concept that the antagonist drugs must act primarily upon the same subcellular receptor sites as do their opiate analogues, and that they must displace the latter compounds from these sites as the mechanism of their opiate-blocking action or a prerequisite to it. The exquisite selectivity of the antagonists in blocking only opiate effects and the exacting chemical and stereoconfigurational requirements for antagonist activity speak strongly for this concept, as does the fact that these drugs possess certain low-grade opiate-like actions (low "intrinsic activity" at the receptor sites) while exhibiting marked potency as antagonists (high "affinity" for the receptor sites). These characteristics are the hallmarks of specific drug antagonism.

Although it is easiest to regard their antagonist activity as being strictly competitive and reversible in nature (as is the case for atropine-acetylcholine antagonism, or Benadryl-histamine antagonism), there are some very unusual and deviant features of the behavior of the opiate antagonist drugs. For example, a single dose of antagonist drug has a much shorter duration of action than does an equal dose of its parent opiate compound, and yet during this brief action the blockade of at least certain opiate effects cannot be overcome by administration of additional, even very large, doses of opiate drug.

Another unusual observation, from both laboratory and clinical sources, has been that opiate antagonism frequently occurs much more dramatically and completely if large doses of opiates have been administered than if small ("therapeutic") doses have been given. A final example is that opiate antagonists are unique drugs in exhibiting one set of actions in nontolerant individuals or animals and an entirely different spectrum of effects in the same individuals when tolerance to opiates has developed.

These atypical characteristics have generated some equally unusual theories to accommodate them; such as the hypothesis that classical drug antagonism is not in-

volved at all, but that effects of the antagonist drugs are seen only when a degree of cellular physical dependence to opiates has occurred—the dependent sites then being released by the antagonist drugs; or again that various types of receptor sites for opiates exist in the same tissue (e.g. stimulant and depressant sites, or cell membrane and intracellular sites) and that the antagonist drugs block selectively at only one of the types of sites. At present there is little evidence to substantiate either of these theories.

An interesting philosophical question is raised by the realization that with the single exception of the opiate antagonist drugs, every known specific drug antagonist is also an antagonist for an active substance normally present in the body and is believed to act at the specific receptor site for that endogenous substance. Our competitive blocking drugs include aldosterone antagonists, acetylcholine antagonists, catecholamine antagonists, histamine antagonists, and serotonin antagonists. Could the phenomenon of the opiate antagonist drugs imply the existence of a still unrecognized endogenous "opium"?

The opiate antagonists have proved to be useful and potentially life-saving drugs when appropriately employed. Their effects include both the remarkable and the bizarre. Perhaps the great contribution they have still to make is that of providing a key to a clear understanding of the nature of action of the opiates themselves.

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DIVERTICULITIS OF THE COLON

By H. R. Reichman, M. D., F. A. C. S., and J. B. Watkins, M. D., F. A. C. S., Salt Lake City, Utah, *Journal of the Michigan State Medical Society*, 61:772–778 (June) 1962.

In a population with rapid marked increase in the older age groups, pathologic processes involving the older age groups can be expected to be more frequently encountered. One of these is the presence of diverticula in the colon. The presence of diverticula is an indication for medical management to prevent diverticulitis and its complications. When the disease process is understood and explained, the majority of these cases can be managed medically. It must be understood by the patient that medical treatment is a control of the condition, not a cure of the condition. In a variable percentage of these cases, depending upon the medical management given, and the adherence to the management followed by the patient, certain complications can be expected to occur. The first of these is diverticulitis. Recurrent attacks of diverticulitis require careful medical and surgical re-evaluation of the patient. Recurrent exacerbation may result in a severe surgical emergency, perforation, peritonitis, abscess formation, fistula, obstruction, particularly with a possibility of carcinoma, and the occasional case of uncontrolled massive hemorrhage are recognized as surgical complications.

In certain cases, evaluation of recurrent diverticulitis should result in elective surgery. Those in the younger age group should be carefully evaluated surgically. It has been shown that the longer diverticulitis is present, the higher the incidence of complications. The only cure for diverticulitis is surgical. To control the condition to an older age increases the surgical risk.

The surgical results in elective surgery have proven to be highly satisfactory by the best qualified of all critics, the patients themselves. The disability, discomfort, pain and anxiety, experienced by the patient with recurrent disease of diverticulitis, are findings which cannot be demonstrated by laboratory tests nor tabulated in statistics. One of the best indications for surgery is to suggest to the patient with recurrent disease the possibility of cure by surgical treatment. The best indication of the success of any form of treatment is the satisfaction of the patient. By these tests, elective surgery where indicated has proven to be highly successful.

Hearing Problems of the Aging

AGING TENDS to deteriorate sensory processes. Among the many deteriorating phenomena is presbycusis, a sensory neural hearing loss. As can be noted from the accompanying chart, it may occur at 50 years of age as an undetected hearing loss of 30 decibels. However, authorities generally agree that it might often start as early as 30 years of age and become increasingly more severe with each succeeding decade of life.

Typically, this problem is a loss of sound in the high frequency range. Thus, certain words can be confused such as "sin" for "fin" or "sink" for "think" or certain speech sounds may not be heard at all. In severe cases some speech may even sound like a strange foreign language.

The aging person who has such a hearing loss tends to withdraw. Family and friends often do not understand the problem and may even consider it to be a sign of senility. If he does attempt to enter conversation he is apt to reply to questions incorrectly and become embarrassed. He might become suspicious or accuse others of mumbling or of not speaking up. His stock phrase is, "I can hear you but I can't understand you." The family's usual reply is "Why don't you buy a hearing aid?" or, "You could hear me if you wore your aid." Actually a hearing aid is a miniature public address system. It amplifies sound but does not interpret it. Hence, the speech discrimination problem is not corrected by a hearing aid.

The erroneous public concept that all hearing-handicapped people can successfully use a hearing aid has led many older people to spend hundreds of dollars on hearing aids in anticipation of hearing normally again. Instead they are disappointed.

The most successful hearing aid users are from 20 to 60 years of age as indicated in Figure 1. With the elderly person, poor health, failing vision, fear, living alone, and many other factors enter into the problem of using a hearing aid successfully. However, reports from the Veterans Administration indicate that with the proper fitting and adequate rehabilitation including speech reading, and auditory training, some elderly people can successfully use an aid. If the aging person would routinely have his hearing checked, begin to use an aid as soon as the loss was severe enough (30 decibels in the better ear), and obtain proper training in the use of an aid, his satisfactory use of amplification would be greatly enhanced.

A four-fold program is necessary to adequately assist the hearing handicapped and his family. It includes education, prevention, diagnosis and treatment, and rehabilitation.

The physician can be active not only in the area of diagnosis and treatment but also in assisting his patients and their families to understand the problem, in early screening for better detection, and in guidance toward proper rehabilitation. The public health worker can be active in educating the public toward the value of routine check-up and screening, toward the importance of obtaining early medical assistance, toward an understanding of the communication problems of the aged, and toward the importance of proper rehabilitation for the hearing handicapped.

In Wisconsin, the Division of Chronic Disease and Aging, with its staff of paramedical consultants in physical therapy, occupational therapy, speech and hearing, medical social work and public health nursing, plays an active role in the rehabilitation of disabled persons. Through in-service education, those working closely with the patient such as nurses, aides, volunteers, and lay persons, gain understanding and skills in assisting him toward his optimum level of rehabilitation. As part of the in-service education, paramedical evaluations of patients are made when requested by the physician

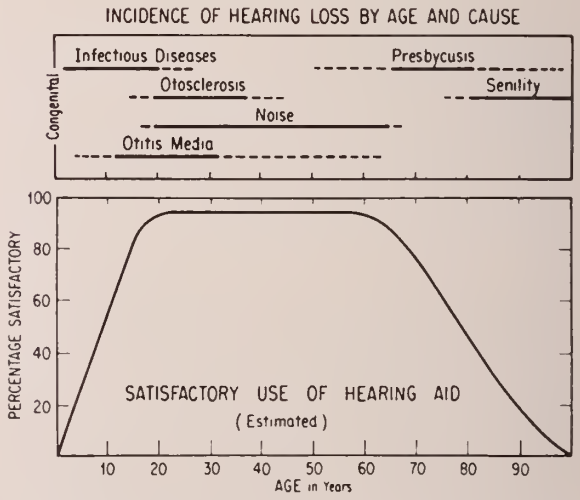

Fig. 1—The chart above indicates the incidence of hearing loss by age and major cause. The solid lines indicate the age period during which the hearing loss is first noted. This chart includes cases with hearing levels for speech better than 30 decibels, but who have levels of 30 decibels or worse at frequency above the range most important for speech as in presbycusis and noise-induced hearing loss.

The graph shows as a function of age the estimated percentage of individuals with hearing levels for speech of 30 decibels or worse who can receive social communication satisfactorily through a hearing aid. (Reproduced with permission of the publisher, Holt, Rinehart and Winston, Inc., New York, copyright 1960, from Davis, Hallowell and Silverman, S. Richard: *Hearing and Deafness*, page 330.)

and advisable rehabilitation measures are suggested. When indicated, the consultant, through periodic visits, assists the nurse and family with the patient.

In the area of hearing some of the following functions might be carried out by the speech and hearing consultant, at the request of the family physician. These depend upon the age, needs, physical and mental condition of the patient:

1. Conduct hearing tests to determine the extent of puretone loss and speech understanding and/or recommend that he go to a rehabilitation center for a hearing aid evaluation.
2. Assist the family, home or hospital in understanding the problem and teach them the best possible method of communicating with the patient regardless of whether or not he has a hearing aid.
3. Demonstrate and periodically advise and upgrade a home hearing therapy program which might include speech reading, auditory training, speech conservation, hearing orientation or hearing-aid orientation. If the initial evaluation and recommendations had been made in a rehabilitation center the consultant could interpret these recommendations to the patient and his family.

This is only a beginning. More education toward prevention, treatment, and rehabilitation of the hearing handicapped is needed in lay as well as professional groups. The problem of hearing loss affects the majority of the older population. Even the fortunate person who escapes a hearing problem must know how to communicate with his next door neighbor, friend, or another member of the family who might be a victim. Dr. Howard Rusk estimated in 1961 that six million people in the United States had impaired hearing and that the incidence rose sharply in people over 40. The large number of persons involved makes this a medical and public health problem.—MRS. JANICE STOVALL, Speech and Hearing Consultant, Division of Chronic Disease and Aging, State Board of Health, Madison.

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BACTERIAL INFECTIONS

Salmonella Outbreak

Frozen chicken appears as the main source of infection in 65 laboratories confirmed and 23 presumptive human cases of *Salmonella hartford*. Cases were found in three midwestern states. In Wisconsin, 22 cases have been confirmed at the Laboratory of Hygiene:

Madison	12
Racine	1
Waukesha	2
Appleton	1
Milwaukee	4
La Crosse	2

Sudden severe diarrhea, frequently bloody, fever to 103 F., and prostration are the most frequent symptoms encountered. No deaths have occurred.

In the past, *Salmonella hartford* has been isolated infrequently. In one series of 28,000 *Salmonella* identifications (1947–1958) at Communicable Disease Center, *Salmonella hartford* appeared only 20 times.

Wisconsin laboratories isolating any enteric pathogen are encouraged to send them to the State Laboratory for further identification.—LABORATORY NEWSLETTER, Vol. 1, No. 1, August 1962, State Laboratory of Hygiene, Madison, Wis.

FIBER GLASS PNEUMOCONIOSIS

Dr. George B. Murphy Jr., of the Gundersen Clinic in La Crosse, Wis., presented a case of fiber glass pneumoconiosis in the December, 1961, *Archives of Environmental Health*. The case was that of an industrial worker who developed a cough, weight loss and hemoptysis following heavy exposure to fiber glass dust from the insulation of old hot water heaters. The hemoptysis was localized by bronchoscopy and its persistence lead to exploratory thoracotomy and lobectomy.

Pulmonary pathology consisted of multiple focal abscesses arising from terminal bronchi and bronchioles which contained minute fiber glass particles. Pathological studies indicated that the particulate matter found in the lung was identical to that obtained from the insulating material and seemed to be minute fragments of fiber glass varying in size from one micron to fibers 14 micron by 60 micron. Three and one half years after resection the patient was well and working.

The condition is apparently relieved by termination of exposure to fiber glass particles. Protection can be secured by the use of an adequate respiratory mask. This mask must be designed to eliminate particles as small as one micron in diameter from the inhaled air.

THE PRESIDENT'S PAGE . . .

Standardized Insurance Reporting

HISTORICALLY, insurance began with a simple plan in ancient Greece. From that time until 1940, when the insurance laws of New York State were revised, legislation recognized 21 types of insurance. It is evident that with increasing technology and stresses of our present day industrial civilization, insurance has divided into almost as many specialties as the medical profession.

It is not strange, therefore, that a multiplicity of insurance forms has developed to cause frustration and confusion in the medical profession and the ranks of hospital administrators. The insurance forms devised by medical societies and hospitals also leave something to be desired as the varying requirements of the different types of insurance are not adequately met.

A general classification of the types of insurance encountered by the medical profession can be listed as follows:

1. *Life insurance.* We must know sufficient details of injuries, diseases, and abnormalities that have influence on long-term prognosis.
2. *Accident and sickness insurance.* These add an emphasis in regard to pre-existing conditions that may occasion early surgery or the probability of early and planned utilization of the insurance by the purchaser.
3. *Casualty insurance.* We must know the occupation of the subscriber as well as any visual, hearing, mental and physical conditions that may make him prone to accidents.
4. *Industrial insurance.* The Industrial Commission and other governmental agencies regulate insurance covering disabilities caused by accidents or illnesses whose source is in the particular industry.
5. *Unusual situations.* The legal profession is involved when the relation of the insurance to the disability, injury or disease cannot be determined without action of a court.

Insurance forms with their necessary information for each type are a daily factor in the successful practice of every doctor. The time has come for the insurance industry and our profession to recognize the problems involved. Through cooperative study, uniform records should be developed

(continued on page 539)

Acknowledges Debt to Family Doctor

I would like to pay homage to the men and women in the medical profession. Especially to the family doctor. I wonder how many people ever really stop and think of the hours they spend trying to keep us well and happy. How many sleepless nights they give so that we may have a restful one.

We complain, I know, of what it costs to go to a doctor, how much money we have to spend through the year for house calls, office calls, medication, etc. Tell me, what price do you put on your life, or that of a loved one? Isn't it worth what it cost, to be free of pain and worry? The agony we go through, when we see someone suffering. I know I could never measure in dollars and cents the payment for return to good health, or the saving of a life. For what good is money, if either of these are sacrificed?

I think of my doctor as the most important person in our lives. Without his concern and endeavor, we could not be a family. His unselfish giving of himself to us, his deep concern and devotion to his practice, and our health, is the greatest accomplishment any human can attain. He is a dedicated person, and in his presence, I feel very humble. They who have such knowledge and skill at their finger tips. They who can change the whole complexion of pain and misery to solace and peace. I know that they are blessed by our Heavenly Father, each day as they go forth to their work of healing the sick and being a comfort to the aged.

God truly loves anyone who gives of himself to others. Besides being our doctor, he is our confidant, close friend and teacher. He praises when we listen, and scolds when we disobey. He is sad and troubled when we are in misery, and happy and relieved when we improve. In other words, to us he is a great and wonderful guy. So I say with utmost sincerity, though we do not always show it, or demonstrate our thanks, Doctor, you are loved, respected and hold a special niche in our hearts that no one can ever replace. May God bless you always, with extra strength and stamina, for each new day. May He bless you with abundant good health so you may have a long and fruitful life. And always remember, when your day seems the darkest, that we love you and need you and will always thank God that you are near.—Mrs. Walter Buss, Menomonie, Wis. (Reprinted from the EAU CLAIRE LEADER, April 25, 1962)

THE PRESIDENT'S PAGE *(continued from page 538)*

for each division. Not only should the questions be the same, but the order of the questions and the spacing should be arranged so a standard typewriter can be used in providing the information.

It would also be desirable to have the forms indicate the purpose for which the information is to be used. In this way, increasing familiarity would result in better reports.

The Health Insurance Council (H.I.C.) has carefully worked out some excellent forms but their lead has not been followed in other fields of insurance.

It is our hope to meet with underwriting and claims representatives of Wisconsin-based companies in the various fields of insurance to discuss the details. With the Medical Society acting as host at such meetings, a cooperative approach to the mutual problems of medicine and its specialties and insurance and its specialties may be of benefit to each party. Much heat and emotion, now existing, may well be cleared away if we can meet around a conference table in friendship and with understanding.

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

A Matter for Urgent Action

WHEN A MOTHER has a child screaming in pain on a Sunday afternoon, nothing can contribute more to her terror and exasperation than to call her family physician and have an automatic telephone answering device refer her to the phone book because the doctor is out of town. On the other hand, there is no more grateful patient—or better friend of the medical profession—than the one that has found the doctor he wanted, or the doctor's colleague, ready to render service in an emergency.

It would be pleasant to report that medical service is actually available to all people everywhere whenever a real emergency arises. Unfortunately, there are many areas of our state where the patient must institute a tracking down procedure to find a doctor who will treat what the patient considers an emergency. Instances have been reported where police have rushed accident victims to hospitals without resident physicians only to find that a doctor was not immediately on hand to treat the injured. Small wonder then, that in some areas the concept of a doctor as a dedicated servant of the suffering has given way to the picture of the physician as a businessman ready to give medical treatment during office hours only.

Whether we like it or not, we must accept as our duty the provision of treatment in any case of emergency to which we are properly summoned. We must accept the fact that an emergency is an emergency when the patient thinks one exists; only afterward, when the doctor has examined the patient, can the actual situation be properly assessed. It is therefore a responsibility of organized medicine to establish a system of emergency service in every area in which it acts. A roster of doctors "on call" must be set up, and its schedule must be rigidly adhered to so that a physician is available at all times.

To make sure that the public knows how to obtain medical service without lengthy search for it, the Commission on Public Relations and Communications of the State Medical Society has recommended that each county medical society should publicize the procedure for getting help in case of emergencies.

Police and fire personnel must be acquainted with the system so they can cooperate with it when the need arises. In addition, hotel and motel operators must be made fa-

miliar with the method for meeting medical care emergencies and for providing aid for those who are visitors in our state or have no family physicians.

Most important, county societies should supervise closely telephone answering services to make sure that any patient who calls is given a reasonable alternative to the doctor he first tries to reach. Reference to the phone book must be avoided; the patient should be given the name and telephone number of a doctor who is "covering" for the absent physician.

County medical societies seeking advice on how to develop workable emergency procedures can call upon the Commission on Public Relations and Communications through the State Society offices. This Commission has acquired a considerable experience with such programs in nearly 10 years of intensive interest in the problem. This experience should not be ignored.

The humanitarian consideration for tightening up the system of providing emergency medical care is, of course, paramount. As an important plus value of our effort in this direction, we will derive a happy bonus of good feeling and staunch friendship for our profession. To assure the prompt appearance of a doctor in an emergency situation is probably the most elementary action we can take to build public respect for our profession.

—D. N. G.

Nutritional Fatuity

NO NONSENSE in the history of mankind has endured so persistently—or profitably for its exploiters—as the food fads. The old fashioned crackpot ideas that some commonly used foods were inimical to good health were bad enough, but they couldn't hold a candle to the fantastic absurdity of the modern diet supplement racket.

According to FDA Commissioner George P. Larrick, the "nutritional quackery" business, as he calls it, amounts to some $500,000,000 a year. Most of it comes from well intentioned, sincere people who can ill afford the additional load on their food budget but who have been gulled by an unconscionable distortion of nutritional facts. The promoters of diet supplements have constructed an entire folklore of misinformation. They take advantage of the housewife's gnawing suspicion that ill health in her family is somehow due to her failure to provide the proper foods. The secret ingredient, say the nutrition racketeers, is removed in processing; the whole trouble, they tell us, is the absence in our foods of health giving qualities which have been robbed in modern commercial preparation. Fortunately, they insist, the arcane quality can be restored to the diet by the purchase and consumption of the diet supplement they sell.

Along with the curious notion that cooking in aluminum—or iron, or steel, or enamel, depending on what the racketeer isn't selling—causes cancer, the diet supplement routine has an appeal to those who take science fiction about food seriously. Usually, they are people who, for one reason or another, have no firm basis for telling the difference between fact and fallacy. If the fallacy is presented to them as fact by a door to door salesman or by a clerk in a retail store, they will accept it and spend their money for the product being promoted until it occurs to them that the promised result isn't materializing. So many and so credulous are such people that untold fortunes have been made by telling them fairy stories about foods. Robert Cummings, the motion picture personality, is quoted by MAC LEAN'S magazine as telling a Canadian convention of Nutri-Bio peddlers: "All my life I have been considered a food nut, an idiot, a faddist and cultist. Now people don't laugh at me any more . . . If they did, I'd hit them over the head with my fat bankbook." Cummings failed to add that the contents of that fat bankbook came from taking advantage of the ignorance of thousands of fearful people who swallowed the idiocy promoted by the organization he partly owns.

Two areas exist for curbing the nutrition quacks. The Food and Drug Administration is at the present time proposing changes in its regulations that will go far to restrict the blatant foolishness of the claims for diet supplements. They will make the marketing of these products more difficult by compelling a more complete statement on the label. The second area is in the education of the people who comprise the market for the diet supplement quacks. Organized medicine as well as individual doctors must launch an emergency program to bring honest information to the public about diet. The information should be *ad hoc* facts relating to specific products being sold in the community, and not general information of the type found in textbooks.

If a reducing bread is being sold in a community, it should be referred to specifically as having less calories per slice because the slices are smaller, and not because it is made differently. If protein supplements are being advertised, public relations committees of county medical societies must see that local newspapers carry stories exposing the particular product and telling the truth about modern food processing. Newspapers should be advised when food-fad advertising is not in the public interest.

The medical profession must go to the people with facts before the people try to find out for themselves or come to us for information. There should be regular and frequent press releases to newspapers, talks to lay groups on the subject, and letters to the editor by individual physicians. The medical profession must declare war on the "health food stores" that bilk the public by encouraging food fads and nutrition quackery.

As we have a responsibility to our patients to expose and eliminate medical quackery, we also have a responsibility to stamp out the multimillion dollar racket of food quackery. Until organized medicine and government agencies can gear up to the task, it is the burden of county societies and each doctor to carry on guerrilla action against the food nut, the idiot, the faddist and the cultist who can hit us over the head with their fat bankbooks. —D.N.G.

COMMENTS FROM THE PRESS

Aggravating Doctor Shortage

In all the debate over medicare in the United States one important aspect of the problem seems to be generally ignored.

This involves answers to the question: "What affect does this have upon young people who are contemplating careers in medicine?"

Recently a well known national publication made a survey to determine the attitudes of young people now taking premedical courses in colleges or attending medical schools. About 70 per cent of those interviewed expressed intense disapproval of any form of socialized medicine.

Some of them even asserted that they would abandon their medical studies or practice elsewhere in the event socialized medicine, such as that established in Saskatchewan, were adopted in the United States. Many of them also looked upon the proposed medicare program for senior citizens as just a step toward socialized medicine.

The minority, individuals of liberal viewpoint, seemed to approve a form of socialized medicine such as that in operation in Great Britain. They evidently liked the prospect of the business security it offers.

But the overwhelming majority resent the threat of government regimentation, and indicated that they would not enter the profession if threat of socialized medicine becomes a reality in the United States.

This should serve as a warning to those reformers and "do gooders" who often rush in with a remedy for every social or political ailment without considering ultimate consequences of their action.

There will be little value to the people if we provide free medical care but have too few doctors to provide the health needs of the people.

We have a serious doctor shortage in the United States now and in the face of our expanding population this will become more serious in the years ahead. Any political course which tends to make that problem more acute is not good statesmanship, in our opinion.—(Editorial, reprinted from the Oconto County Reporter, Aug. 2, 1962)

A Hospital Pathologist

Recently my 9-year-old daughter was rushed to a hospital in an unconscious state.

An examination at the hospital pointed to barbiturate intoxication (overdose) yet other causes were possible. It became necessary to perform a chemical test. The hospital was not equipped to perform such a test and much time was spent in an attempt to have the test performed at another hospital or a clinical laboratory in the city.

Being Saturday, nowhere could the test be done and it was thought that the test would have to wait until Monday.

Thanks to the hospital pathologist, who returned to the hospital Saturday evening (his day off) and diligently worked from 8 that evening until 4:30 the next morning, the test was performed and an early diagnosis confirmed.

In talking to the pathologist, something he said in connection with this matter should not go unnoticed. He said: "There ought to be some place in Milwaukee where any necessary test can be done at any time and if this has to be the hospital and I have to be the man, it will be done."

Such dedication merits recognition and public thanks.—William W. Ward, Greendale. (Reprinted from the *Milwaukee Journal*, Aug. 26, 1962)

THE MEDICAL FORUM

Taxpayer-Identifying Numbers Required of All Physicians for 1962 Tax Returns

Under authority contained in Public Law 87–397 (Oct. 5, 1961), relating to taxpayer-identifying numbers necessitated by the installation of the automatic data processing system by the Internal Revenue Service, the Commissioner of Internal Revenue, on August 24, 1962, adopted regulations requiring taxpayers and payers of income to obtain and use identifying numbers. The regulations term the number prescribed for use by an individual an "account number."

Since 140 million Americans already have Social Security numbers, it was decided to use these numbers to avoid the inconvenience of obtaining other numbers. Thus, the account number which an individual will indicate on a return or other related document will also be his Social Security number.

Unless a physician is or was ever an "employee," it is unlikely that he will have a Social Security number since doctors of medicine who are self-employed are excluded from coverage under the Social Security system. However, since *every* person required to make a return, statement, or other document for any period commencing after 1961 with respect to his tax liability, must have an account number, physicians will have to obtain such numbers even though they are not covered under the Social Security system.

According to the regulations, application forms for use in obtaining account numbers will as far as possible be furnished *without* request during 1962 to taxpayers needing numbers. Thus, a taxpayer is not required to file an application for an account number during 1962 *unless* furnished with an application. A taxpayer who has been supplied with an application form *must* file it in accordance with the instructions for such form.

After 1962, an individual needing an account number *must* file an application for an account number on either Form SS-5 or Form 3227. An application form may be obtained from any District Director, or any District Office of the Social Security Administration.

An individual engaged in a trade or business is also required to obtain an identifying number which is termed an "employer identification number." For this (and our)

(continued on page 547)

Seven Regional Conferences Planned in Nov. on President's Physical Fitness Program

Co-sponsorship of seven regional conferences to acquaint Wisconsinites with the second phase of the President's physical fitness program was approved Sept. 26 by the Division of School Health of the Commission on State Departments.

The conferences will be held in late November in various sections of the state for physical education instructors, school nurses, other teachers interested in health, PTA health chairmen and physicians.

Initiated by the Department of Public Instruction, they will be cosponsored also by the State Board of Health and State Medical Society.

The second phase of the President's program will stress health appraisals of school children.

REPORT ON ATHLETIC INJURIES

The Division also heard a report on athletic injuries clinics held during the summer, and reaffirmed its interest in such clinics. Plans are underway to cooperate with the Wisconsin Interscholastic Athletic Association in similar events in 1963.

In other actions the Division:

1. Reaffirmed its previous statements urging physicians and parents to make maximum utilization of immunization procedures available, rather than advocate legislation for mandatory smallpox immunization for school children.
2. Approved an outline of a conference on youth and health to be held during the Wisconsin Work Week of Health, February 16–23, 1963.
3. Offered its advice to the Wisconsin Interscholastic Athletic Association on various matters.

In this latter category, two problems involved the W.I.A.A. Examination and Permit Card which the student has filled out by a physician prior to athletic participation. Problems have been encountered in obtaining urinalysis information and specific details on physical weaknesses which may limit participation.

John Roberts, executive secretary of the W.I.A.A., reported that the "full payment" plan of the organization's benefit program is progressing well, with half of the schools in the state participating.

Medical Self-Help Program To Be Continued

Thirty-nine Medical Self-Help Training courses, involving 1,030 citizens, had been held in Wisconsin as of August 31, 1962. The state ranks seventh in the nation in the number trained.

State Civil Defense Health Services has requested additional kits to supplement those kits already received. The State Medical Self-Help executive committee will evaluate the effectiveness of the program as conducted during the testing period, and a revised state plan will be issued and kits allocated in accordance with that plan.

EXTERNAL CARDIAC MASSAGE was also included in the instructional program presented by the physicians of the Monroe County Medical Society for students at the Wisconsin State Patrol Academy at Camp McCoy. Dr. C. B. Koch of New Lisbon demonstrates the technique for a number of the officers. The manikin and a film on the subject were provided by the State Medical Society and are available for community programs conducted by physicians. (A detailed report of the hazards and benefits of the closed chest method of cardiopulmonary resuscitation appears on page 42 of this issue.)

STATUS OF PROGRAM

The Office of Civil Defense and the Division of Health Mobilization, U. S. Public Health Service, have released a statement outlining the status of the Medical Self-Help Program. Portions of that statement of concern to state and local agencies and personnel are as follows:

1. The training program will be continued even if there is no increase in Congressional appropriations during fiscal year 1963.
2. Revisions of the training kit materials as recommended by an advisory committee and others are under way.
3. Anticipated timing of Congressional action and production schedules should make additional training materials available by January 1963. Unexpected delays could affect this timing.
4. Sufficient back-up materials (student handouts) are now available to keep the kits, which have been distributed, busy until new materials will be available. These materials can be shipped *immediately* by proper use of the IBM reorder card provided with each kit and each package of student materials. It is important that the kit number be shown on all reorder cards.

THE MONROE COUNTY MEDICAL SOCIETY, in cooperation with the State Medical Society and Wisconsin State Patrol, recently conducted a series of training sessions for state patrolmen at their academy at Camp McCoy. Above Sgt. Corwin Holmquist of the Wisconsin State Patrol and Dr. J. S. Mubarak, Tomah, observe as Sgt. Ivan Anders practices mouth-to-mouth resuscitation.

The Civil Defense Division of the Wisconsin State Board of Health urges the full utilization of existing training kits and suggests that kits be used by more than one instructor. Any kits and unused student materials which are not going to be used should be returned to the agency or person that issued the kit after first informing that person they will be returned. Individuals or agencies desiring kits should make requests to the county civil defense director or the State Board of Health office, indicating the instructor's name and location of the course.

Commitment Enabling Legislation Discussed

The institution of proper mechanisms for the release from custody of those adjudged insane, which would involve the continued supervision of the potentially dangerous individual following release, was discussed by the Committee on Commitment Laws of the State Medical Society at its meeting in Madison on September 29.

Exemplified by the case of Terrence **Donovan**, a young Peshtigo parolee with a history of mental illness who wantonly killed a 21-year-old Milwaukee girl and seriously injured her husband early in 1961, the general problem is one which produces spontaneous public outrage but lacks planned social response for a solution.

Under the American juridical structure as it now stands, punishment, and a determination of the personal responsibility of the person adjudged, follows the act. To protect the community from the mentally ill who do not fit into present legal definitions is both a legislative and administrative problem.

The Council of the State Medical Society referred this matter to its Commission on State Departments with a suggestion that a joint conference be arranged with representatives of the State Bar of Wisconsin and others representing medical and sociologic interests. As a result, the Committee on Commitment Laws, which is part of the Division on Nervous and Mental Diseases of the Commission, has proposed:

1. Formation of a committee to help formulate additional legislation for persons committed after being adjudged not guilty, or unable to stand trial for a crime, by reasons of insanity;
2. The committee need not be concerned with civil commitments, at least initially;
3. If during their commitment individuals are believed to be potentially dangerous following release, arrangements should be made for continued supervision for as long as this danger exists;
4. The committee should formulate appropriate legislation to provide for administration of such supervision and for necessary legal control to see that they continue under this supervision.

Members of the Committee on Commitment Laws include: Drs. A. A. **Lorenz**, Eau Claire, chairman; Keith M. **Keane**, Appleton; Charles A. **Wunsch**, Green Bay; T. J. **Nereim**, E. M. **Burns** and Walter J. **Urben**, Madison; Charles H. **Belcher**, Winnebago; J. T. **Petersik**, Oshkosh, and Charles W. **Landis**, Milwaukee; and Asher **Pacht**, chief clinical director, Wisconsin Department of Public Welfare.

Meeting with the committee were: Sanger B. **Powers**, director, and H. T. **Bassett**, Division of Corrections, State Department of Public Welfare; Irwin D. **Rinder**, associate professor, sociology department, University of Wisconsin; Frank J. **Remington**, professor of law, University of Wisconsin; Dr. L. J. **Ganser**, director, Mental Hygiene Division, State Department of Public Welfare; Dr. T. W. **Tormey**, Jr., Madison, chairman, Commission on State Departments; Dr. W. J. **Egan**, Milwaukee, president-elect of the State Medical Society; Circuit Judge Norris A. **Maloney** and Dane County Judge Carl **Flom**, Madison.

MARQUETTE RECEIVES $150,000 GIFT

An unrestricted grant of $150,000 has been given to the Marquette University School of Medicine by the Josiah Macy, Jr., Foundation. It will be used in support of faculty salaries, particularly in the basic medical sciences.

Named to Foundation Advisory Board

W. B HILDEBRAND, M.D.

Dr. W. B. **Hildebrand**, Menasha, has been named by the American Medical Association to the advisory board of the Sears Roebuck Foundation. His term becomes effective June, 1963.

Four-year memberships to the board rotate every two years with one-half of the board retiring at that time.

The Sears Roebuck Foundation sponsors a substantial program to assist communities in finding physicians. It also assists physicians in establishing practices through a loan program.

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DEDICATION OF THE STOVALL HALL OF HEALTH took place Sunday, September 23, at the Museum of Medical Progress in Prairie du Chien, Wis. Taking part in the ceremonies were, left to right, Clifford Lord, New York, former director of the Wisconsin State Historical Society and now dean of the School for General Study at Columbia University; Dr. George M. Fister, Ogden, Utah, president of the American Medical Association; Dr. William D. Stovall, Madison; and Dr. E. M. Dessloch, Prairie du Chien, fourth district councilor of the State Medical Society. The new building, third in the medical museum complex, is named in honor of Doctor Stovall, president of the Charitable, Educational and Scientific Foundation of the State Medical Society.

Memorial Lecture Speakers Named for Annual Meeting

Memorial lecture speakers for the 1963 annual meeting of the State Medical Society were designated at the September 22 meeting of the Commission on Scientific Medicine held in Milwaukee.

Dr. Ivan D. Baronofsky, San Diego, Calif., was selected to deliver the Beaumont Memorial Lecture. Doctor Baronofsky, a graduate of the Marquette University School of Medicine, will be the fourth Beaumont Memorial lecturer. Established by the Council of the State Medical Society in 1957 to honor Dr. William Beaumont, pioneer in physiology, the memorial lecture has been presented by Dr. Burrill B. Crohn, New York City, in 1958; by Dr. Franz J. Ingelfinger, Boston, Mass., in 1959; and by Dr. Charles W. A. Falconer, Edinburgh, Scotland, in 1960.

Dr. Frederick J. Stare, Boston, Mass., was selected to present the Elvehjem Memorial Lecture. Established this year, this lecture honors the late Conrad A. Elvehjem, Ph.D., president of the University of Wisconsin and international authority on biochemistry, who died July 27.

These memorial lectureships are administered by the Foundation of the State Medical Society, the Beaumont lecture as an annual event of the Annual Meeting, and the Elvehjem lecture as the occasion might present itself.

Program plans for the 1963 annual meeting are practically complete. Several Marquette alumni will participate in recognition of the medical school's fiftieth anniversary. Among them are: Dr. Robert W. Bailey, department of orthopedic surgery, University of Michigan Medical School, Ann Arbor; Doctor Baronofsky; Dr. John L. Bonica, professor and chairman of the department of anesthesiology, University of Washington School of Medicine, Seattle; Dr. J. E. Geraci, clinical section, Mayo Clinic, Rochester, Minn.; Dr. E. Val Hastings, assistant professor of pathology, Medical College of Georgia, Augusta; Dr. John Romano, professor of psychiatry and psychiatrist-in-chief, Strong Memorial Hospital, University of Rochester School of Medicine, Rochester, N. Y.; and Dr. John S. Stehlin, Jr., associate surgeon, M. D. Anderson Hospital and Tumor Institute, University of Texas, Houston.

3,375 Radiation Sources Registered in Wisconsin

In compliance with legislation passed by the 1961 Legislature, 3,375 radiation sources have been registered in the state. More than one person may use equipment under one registration, as in a clinic or hospital, and more than one piece of x-ray equipment may be included under one registration.

A breakdown of those registering x-ray equipment shows:

Physicians	791
Osteopaths	59
Chiropodists	73
Chiropractors	321
Dentists	1802
Veterinarians	76
Industries	63
Hospitals	167
Others	23

The registration forms, which must be filed with the Industrial Commission, call for:

1. Names and addresses of the owner, user and person responsible for radiation safety.
2. Type of source.
3. Application.
4. List of machines and maximum kilovolt peak.
5. Maximum milliamperes.
6. Source strength of radium, and whether sealed or unsealed.

Failure to register could bring a fine up to $500, imprisonment up to 6 months, or both.

WISCONSIN WORK WEEK OF HEALTH

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. . . public health and Wisconsin
. . . industry and health
. . . medical education and hospitals
. . . interprofessional relations

MARK YOUR CALENDAR NOW

MISS ALICE BUDNY, MILWAUKEE, new president of the American Association of Medical Assistants, receives congratulations from Dr. D. E. Dorchester (right), Sturgeon Bay, and Dr. Wayne Fencil (left), Monroe, at the group's national convention in Detroit September 26 to 30. Doctor Dorchester was elected to AAMA's national advisers' committee and Doctor Fencil is an honorary member of the Wisconsin chapter of medical assistants.

Taxpayer-Identifying Numbers

(continued from page 543)

purpose, an individual is considered to be engaged in a trade or business if any return is required to be filed by him as an employer (other than a household employer) with respect to his liability for the Social Security taxes imposed under the Federal Insurance Contributions Act and the provisions of the Internal Revenue Code which require an employer to withhold income taxes from the wages of employees. Thus, such an individual may not only have an account number but an employer identification number. And, under the regulations he is required not only to include his account number in the appropriate return, statement or other document but also to include his employer identification number in the schedule provided for reflecting profit or loss from a business or profession.

Obviously, a physician-employer is required to obtain an employer identification number if he doesn't already have one. This is unlikely if he has been an employer for some time. If a number has not been assigned, then application therefor must be made on Form SS-4 to any District Director or any District Office of the Social Security Administration office. Referring to the requirement as to the inclusion of account numbers and employer identification numbers, a physician employer would have to include his account number on his income tax return (or declaration of estimated income tax) and his employer identification number on Schedule C of Form 1040 (Profit [or Loss] from Business or Profession).

An income tax return or a declaration of estimated income tax filed jointly by a husband and wife need include only the account number of the husband. However, a wife's account number must also be shown if, for the taxable year covered by the return or declaration, the wife has (a) separate gross income of $600 or more, or $1,200 or more if she has attained the age of 65 before the close of the taxable year, (b) self-employment income, or (c) income (such as wages, dividends, or interest) paid to her otherwise than with her husband which the payer thereof is required to report on a return or statement of information.

The law and regulations impose a penalty for failure to include the identifying number in any return, statement, or other document, or when otherwise required. The penalty is $5 for each such failure.

The pertinent income tax regulations are as follows: Regulation Sections 1.6109–1, 31.3402 (f) (2)–1 (d), 31.6001–5, 31.6011 (b)–1, 31.–6051–1, 31.6109–1, 301.6109–1, 301.–6676–1, and 301.7701–11—301.–7701–13.

BLUE SHIELD PLANS SHOW INCREASE

National enrollment figures for the 76 Blue Shield plans in the country for the first six months of 1962 show a total of 47,094,846 persons covered.

This is an increase of more than 1.5 million over the 1961 figure for the same period.

For Wisconsin Physicians Service the report shows 244,676 persons covered, including 98,592 subscribers and 146,084 dependents.

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Sculptural Wood Carving Given Foundation

Prominently displayed at the State Medical Society headquarters at Madison is an impressive Beaumont bas-relief, a recent gift to the Charitable, Educational and Scientific Foundation from Mrs. D. B. Dana of Ephraim, widow of Doctor Dana, formerly of Kewaunee. Early next year, it will be on display in the Museum of Medical Progress at Prairie du Chien.

The bas-relief is a dramatic work of art approximately three feet wide and two and one half feet high and about four inches deep. It is a sculptural wood carving apparently done with a single piece of wood by Robert Petschweider, Kewaunee, after the oil painting by Dean Cornwell.

The famous scene depicts Dr. William *Beaumont* studying the digestive process of the stomach through the permament gastric fistula of Alexis *St. Martin*, Fort Mackinac, Mich., May, 1825. The scene is laid in Doctor Beaumont's home at Fort Mackinac, and the characters depicted are Doctor Beaumont, St. Martin, Doctor Beaumont's Indian servant and her child.

THE HISTORICAL BAS-RELIEF recently donated to the Museum of Medical Progress by Mrs. D. B. Dana, Ephraim, depicts Dr. William Beaumont studying the digestive process of the stomach through the permanent gastric fistula of Alexis St. Martin, Fort Mackinac, Mich., May, 1825. The other characters are Doctor Beaumont's Indian servant and her child.

DATES AND DAYS OF FUTURE ANNUAL MEETINGS

For several years efforts have been made to shift the Annual Meeting back to the fall, but suitable dates and facilities are not available in Milwaukee and present plans are to continue the Annual Meeting of the State Medical Society in May.

Because of a continuing conflict with national research meetings in Atlantic City the first week in May, efforts are being made to have the Annual Meeting held in the SECOND WEEK IN MAY, with scientific programs starting on Monday and continuing through Wednesday, instead of Tuesday through Thursday, as in the past several years. This change cannot be made before 1964 or 1965.

DATES OF THE ANNUAL MEETING FOR 1963—MONDAY, MAY 6 THROUGH THURSDAY, MAY 9.

Wisconsin Physicians Attend Mental Illness and Health Congress

Thirty-six Wisconsin representatives, including 13 physicians, attended the National Congress on Mental Illness and Health held October 4–6 in Chicago. The congress was sponsored by the American Medical Association's Council on Mental Health.

Purpose of the congress was to implement the broad, new mental health program developed by the American Medical Association.

Developments from this congress will be assessed at regional meetings with eventual outlining of special problems and priorities for action at regional, state and local levels.

After an opening general session on Thursday, the Wisconsin delegation met separately all day Friday to discuss implementation in this state. A summary conference on Saturday concluded the meeting.

Physicians attending were Doctors B. Cullen Burris, Chris J. Buscaglia, Charles W. Landis, E. M. Paine, Ray Piaskoski, Ervin Teplin and John S. Hirschboeck, all of Milwaukee; Leonard Ganser, James Wardlaw and T. J. Nereim, all of Madison; Keith Keane, Appleton; O. A. Dittmer, Ripon; and Loren Driscoll, Oconomowoc. Doctor Keane, as chairman of the Division on Nervous and Mental Diseases of the Commission on State Departments, represented the State Medical Society.

Communities Seek AMA-Foundation Aid

Citizens of Randolph, Wis., have met the requirements of the A.M.A.-Sears Roebuck Foundation Medical Assistance Program but because of their proximity to Fox Lake, a former cooperating community which recently obtained two physicians, the Foundation is unable to assist them.

Dr. H. Leering of Cincinnati, Ohio, has announced his intention of opening his practice in Reedsville. Reedsville is the fifth community in Wisconsin to successfully obtain a physician under this Plan.

Special OB Nurse Training Program Studied

Medical staffs of Wisconsin hospitals will be interested in a new nurse-training program being studied by the Wisconsin State Board of Health and the Division on Maternal and Child Welfare of the State Medical Society's Commission on State Departments, which would give special status to an obstetrical nurse similar to the current status of a surgical nurse. The study would initiate an intensive training program for selected nurses, with proposed pilot programs to be carried out in Milwaukee and Madison hospitals.

If the proposed program is finalized, a small group of nurses recommended by individual medical staffs of hospitals will be given special training in obstetrical procedures which are routinely regarded as responsibilities of physicians but which could be carried out by trained nurses on an emergency basis or on standing orders of the medical staff.

"With population increases exceeding the increased number of physicians," commented Dr. John **Evrard,** Milwaukee, chairman of the Division on Maternal and Child Welfare, "those of us concerned with obstetrical services in Wisconsin wish to meet the anticipated situation through the regular channels of medicine and nursing, rather than creating a licensed midwife, as is being proposed in some of the states. We feel that if each hospital has a skilled nurse to assist as problem cases arise, we can achieve the goals of patient welfare without creating an ancillary service which is outside of the province of medicine itself."

If the Division and the State Board of Health can agree on the content of a pilot training program, it is anticipated it will be organized on a test basis sometime during 1963. If successful it will be expanded to other areas of the state.

Teaching Programs Scheduled for 1963

Postgraduate teaching programs for Wisconsin physicians are being arranged for early in 1963, it was reported at the meeting of the Commission on Scientific Medicine of the State Medical Society held September 22 in Milwaukee.

Tentative dates are Tuesday, Wednesday and Thursday, February 26–27–28, for a contemplated program by Drs. George E. **Collentine,** Jr., Burton A. **Waisbren** and Gerald A. **Kerrigan,** all of Milwaukee, to be held in Green Bay, Antigo and Neillsville.

A detailed program of conferences "Clinical Electrocardiography," scheduled for October 18 at Dodgeville, November 8 at Rhinelander, and November 15 at Rice Lake, appeared in the September issue of the *Wisconsin Medical Journal.* An earlier three-day program on "Strokes" took place in October.

The postgraduate teaching programs are a project of the Charitable, Educational and Scientific Foundation of the State Medical Society under grants received from cooperating sponsors.

W.A.M.T. OFFICERS ELECTED

Newly elected officers of the Wisconsin Association of Medical Technologists are Kenneth J. **Smith** Brookfield, president; Mary Kay Giese **Moon,** Menasha, president-elect; Jerome **Fitzgerald,** Fond du Lac, treasurer; and Ruth **Dunham,** Wauwatosa, secretary.

"HOBBIES FOR HEALTH", a CES Foundation project, shows a promising beginning with the initial donation of 17 occupational and fraternal shaving mugs of a bygone era. The Milwaukee physician who made the donation prefers to remain anonymous. The personal shaving mug of Dr. W. F. Lorenz, 1882–1959, Wisconsin pioneer in the field of preventive psychiatry, recently was added to the collection by Mrs. Vera K. Meyer of Madison. Earlier, in 1961, John B. White, Madison, gave the Foundation a mug which had belonged to Captain Blend who sailed the M. S. Scott out of Milwaukee in 1859. The mugs are shown above as they appear in the glass showcase in the reception area of the State Medical Society headquarters.

Two Health Guides Reviewed

The Commission on Public Relations and Communications, of the State Medical Society meeting in Milwaukee September 16, approved revision and reprinting of the Wisconsin Occupational Health Guide for Medical and Nursing Personnel as recommended by the Committee on Occupational Health of the State Board of Health.

The Committee on Occupational Health, which met in Milwaukee September 15, also reviewed the draft of an Occupational Health Guide for Hospital Personnel which had been prepared by a joint committee of the Wisconsin Hospital Association, State Medical Society, Wisconsin Nurses Association, and the Wisconsin State Board of Health.

The purpose of this publication is to provide some guiding principles and recommendations that have been thoroughly studied and agreed upon by this joint committee in an attempt to assist all persons concerned with establishing and implementing employee health programs in hospitals.

Public speaking appearances by physicians on socio-economic subjects were discussed and it was suggested that all county medical societies set up speakers bureaus.

Commission approval was given to the Occupational Health Committee's proposal that short articles on occupational health be prepared by its members for publication in the *Wisconsin Medical Journal.*

A congratulatory message was sent by the Commission to Miss Alice **Budny**, Milwaukee, upon her installation as national president of the Medical Assistants Society.

PKU Film Available

"PKU Mental Deficiency Can Be Prevented" is the title of a new 14 and one-half minute sound film produced under the supervision of Dr. Harry A. **Waisman**, department of pediatrics, University of Wisconsin Medical School. Presenting case histories of two siblings, both with phenylketonuria, the film reviews the biochemistry, genetics, symptoms, diagnosis and management of PKU.

The film is available for showings, without charge, to medical groups and organizations. Requests for loan of prints should be sent to Medical Film Department, Ames Company, Inc., Elkhart, Ind.

Wisconsin Data Used in Crash Injury Study

A total of 200 motor vehicle accidents, involving 324 case histories, were included in the first year's study of crash injuries in Wisconsin, according to a report received September 27 by the Division on Safe Transportation of the State Medical Society's Commission on State Departments.

The study is being carried on by Automotive Crash Injury Research of Cornell University in cooperation with the State Medical Society, State Board of Health, Wisconsin Hospital Association, and State Motor Vehicle Department.

Data collected by state patrolmen, hospitals and physicians is utilized to bring about changes in design in automobiles to reduce the number of fatalities and extent of injuries in accidents.

The study is continuing through June, 1963, and will tabulate the number of persons killed or injured in accidents involving recent model automobiles.

In its report the Cornell study group expressed appreciation to Wisconsin physicians for their cooperation in the program.

FOURTH YEAR MEDICAL STUDENTS at the University of Wisconsin, under the direction of Dr. Alfred S. Evans, professor and chairman of the department of preventive medicine at the university, visited the State Medical Society office building in Madison September 18. The group represented half of the senior class; the other half will visit the building on December 11. The medical students heard presentations on "Organization and Functions of Your Medical Societies," "Legal ABC's for the Young Physician," and a discussion of "General Practice vs. Group Practice." Participating in the latter discussion were Dr. Phillips T. Bland, Westby, a general practitioner, and Dr. Leslie G. Kindschi, Monroe, specialist in internal medicine. A tour of the Society building was included in the program.

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Children's Personality Reaction to Chronic Illness

By HAROLD F. BORENZ, M. D.
Madison, Wisconsin

CHRONIC ILLNESSES in children are many with each disease having its particular implications. As we learn more about various forms of illnesses, we soon arrive at the indisputable fact that no illness, chronic or acute, is without its emotional implications whether they be far-reaching and permanent or acute and transient. These illnesses may be divided into three groups:

1. *Psychosomatic,* with a primary emotional etiology interwoven with somatic dysfunction. These consist of obesity, neurodermatitis, psychogenic megacolon and certain cases of asthma.

2. *Somatopsychic,* in which a primary physical disability has emotional and personality effects such as congenital heart disease, nephritis, poliomyelitis and brain damage.

3. *Psychiatric,* with primary emotional etiology and without significant or only transient physical dysfunction. School phobia, enuresis, phobic reactions, and obsessive, compulsive and sexual identity deviation are examples.

Involved in a study of children's personality reaction to chronic illness are a variety of topics and considerations. Since most chronic illnesses require varying lengths of hospitalization, the factor of separation from the family with its attending anxiety in both the child and the family needs to be considered. Another problem is the meaning of the illness to the child and the family in terms of both immediate and long-range effects. In most instances the pediatrician has not one patient but three, consisting of the child as well as the mother and father. Proper assessment of each of these person's understanding of the illness and cooperative participation provide the background for easier application of medical treatment. Combined with these is the fact that the child stricken with a chronic illness is at some stage in his personality development with varying capacities to understand the complex events happening to him. This, in children of most ages, leads to fantasied distortion sometimes fostered by unwise remarks by nurses, parents or others. These emotional reactions may lead to chronic invalidism beyond the physical disability, prolonged dependency and an emotionally crippling state.

Presented at the annual meeting of the State Medical Society, Milwaukee, May 9, 1962.

Doctor Borenz is Associate Professor of Psychiatry and Director of the Child Psychiatry Division of the University of Wisconsin Medical School.

It may be said in a general way that all efforts to reduce excess anxiety in the child will aid the healing process, whatever the disease. Studies on human subjects by Wolff[1] have shown that emotional stress consisting of alertness, vigilance or readiness for action evokes pressor responses to increase significantly the work of the heart and to reduce visceral circulation strikingly. The effective renal blood flow may be reduced 40 to 50 per cent, sometimes long outlasting the immediate periods of threat.

Knowledge of the physiological concomitants of anxiety have become better known with the many studies since Cannon's original papers. Most of these have occurred in adult subjects. Only recently have similar studies been done on children; namely, Spitz,[2] Bowlby,[3] and Blom,[4] and most currently the work of Garner and Wenar[5] on psychosomatic disorders of children. This group of chronic illnesses often presents the most baffling and the greatest challenge to pediatric practice. Such diseases as atopic eczema, rheumatoid arthritis, peptic ulcer, ulcerative colitis and bronchial asthma fall within the group studied in children.

Several findings from this study support previously suspected clinical impressions. It is an accepted fact that the infant and young child have poorly integrated physiological functions. It has long been suspected, without documented proof, that this physiological integration of the gastrointestinal tract, the neuromuscular system, the cardiorespiratory system and the external integument, the skin, is dependent upon having the young organism's needs met with a minimum of disruptive anxiety or frustration through the subtle but vital and complicated process of mothering.

In the psychosomatically ill children, this early period in their lives was found to be particularly unwholesome. Quite uniformly the mothers of these children enjoyed their pregnancy and had uneventful deliveries. They had high expectations for their children and eagerly looked forward to caring for the infants. Once engaged in this, however, their eagerness faded to frustration and discouragement. These mothers persisted in attempting to direct and control the infants in a highly emotional fashion which caused them to be driving, rigid and expecting conformity. There was little tenderness, spontaneous enjoyment or casualness in the child-caring process. The infant took on the characteristics of a "project" fulfilling the goals of the mother who had little regard for the individual needs and satisfactions of the child. From the child's standpoint, he did not receive the type of continuous protection from distress which is so important to the achievement of physiological integration.

Such treatment serves to perpetuate a pattern of diffuse, extreme and erratic response to stress. It also arouses in the infant the gradual awareness that in his interpersonal environment intimacy is closely associated with distress. The impersonal, shallow and, at times, vacuous personality of the child with psychosomatic illness is so frequently seen and related to this early life experience. It is to be noted further, and is important in pediatric care, that these disorders from a personality standpoint are not easily modified. The underlying personality structure more closely resembles the child with psychosis rather than neurosis.

Children's inner fantasies and unexpressed feelings are often difficult to probe, yet they determine their attitude and reactions to medical procedures and hospital adjustment and may interfere with the orderly progress of personality maturation, well described by Cooper.[6] The nature of the interfering inner fantasies and reaction to illness in the child is dependent upon the child's age, previous relationship with his family, the nature of the illness and the way in which medical personnel deal with the child.

Prugh[7] found that children's reaction to illness, and particularly hospitalization, varies significantly with age. Preschool children, especially those under three years of age, often react to separation from the mother by misinterpreting this act as punishment or desertion regardless of the medical diagnosis or treatment. Those children over three years of age, while reacting to some of these fantasies, react more strongly to fantasies of bodily mutilation and death fears. These older children see involved in medical procedures a punitive significance related to earlier misbehavior on their part. A six-year-old boy with nephrosis, for example, understood from his mother that he had "blood pressure," and that he must not ride a bicycle since that

would raise his blood pressure and blow the top of his head off and he would then die in the explosion.

Garner and Wenar[5] studied children with various illnesses by means of a special projective technique in which each child was asked to make up stories about figures of children who were ill with various disorders. Analysis of the children's responses showed three groupings of elaborated fantasies regarding the cause of illness. The first consisted of themes dealing with troubled relationships with people, particularly parents and siblings. The fantasies in this category consisted of such ideas as the child got sick because "he got mad at his mother," or had surreptitiously eaten some food forbidden by the parents. This latter reaction may often be seen in illnesses requiring special diets where the parents and medical personnel by their attitude attach a dangerous quality to certain foods so that the child is in a state of confusion and anxiety over eating, not knowing which food is "safe" and which is dangerous and poisonous.

The second grouping of children's fantasies regarding the origin of illness was their belief that God was responsible. This took on various qualities. In some children, this was equated with fate and the illness was endured as part of life. In others, it took on a punishment aspect for wrong-doing leading to a feeling of badness, self-depreciation and inhibition with depressive features. In other instances, the children fantasied that God had chosen them to have this illness as a special mark of distinction approaching a martyr role.

The third category of responses involved the fantasy of contagion—believing the illness was caused by being with others who were sick. This fantasy developed in children who did not have any truly contagious diseases. One can easily imagine the effect of such a fantasy on children who would then be fearful of being close to others for fear of catching some disease as well as envisioning themselves as dangerous to others. This could well add to the basic damaged self-concept occasioned by the illness.

It is of interest that children with psychosomatic disorders tended to evolve fantasies of the origin of their illness as related to troubled interpersonal relationships while those with more clearly somatic illness tended to see the origin arising from fate or God. This may well reflect some intangible awareness on the part of the psychosomatically ill children of the importance of emotions and feelings toward people as playing a part of their symptoms.

The reaction of parents to the chronic illness of their child is an important factor of pediatric practice. While interpretation of the child's illness and care to the parents is time-consuming, it results in smoother patient care than any known substitute. It is hoped that the pediatrician can find sufficient skill and confidence in interpretation to the parent of the child's illness to see this as challenging, worthwhile and gratifying. To find this task odious, avoiding it or referring it to others, often leads to continuing parental confusion or anxiety reflecting itself in poorer care of the child as well as opening the possibility of "medical shopping." Perhaps the most noteworthy case of this type is the retarded child.

Parents' reactions vary according to their own personalities as well as the nature of the child's illness. The child's illness may, for example, be endangering the life of the child, produce physical disability or mental disability. In spite of the different reactions of the parents to these conditions, certain common reactions occur. The first is that the parents must shift their goals for the child. A business man, for example, realizes that his only son cannot continue the father's business. In another instance, the parents cannot realize their goal of having their child advance farther academically than they did. In psychiatric language, the realization of this results in a *grief reaction* akin to *mourning*. This grief reaction may be handled by the parents in several ways. Tisza[8] has described how the parents may deny the extent or seriousness of the illness. In some instances, they may blame others such as the pediatrician or other persons for the condition of their child. Parents may at other times blame and condemn themselves in an overly self-critical way. Others may accept the illness with a religious acknowledgment, that it is the will of God not to be questioned by themselves.

The duration of the parents' grief reaction and the resolution of it in an emotionally healthy or unhealthy way, varies in relation to the parents' personalities and the help they receive. In any case, it usually re-

quires at least several days and in most instances several weeks to resolve.

Harmful effects of a poorly resolved grief reaction in the parents can take many forms in interfering with the child's optimum progress with his illness. It is significant that in this regard 8 of the 20 cases Levy[9] studied as the basis of his classic work on maternal overprotection were children with a chronic illness. Pediatricians are all too familiar with this type of parental reaction.

Pediatricians presented with these problems find no easy resolution. The first discussion with the parents informing them of the diagnosis should not be too extensive or detailed beyond a general statement. At some later time, it is best to give a more detailed discussion of the therapeutic and remedial measures which might be employed in succession for the child's rehabilitation. This introduction of a plan of action lends a note of appropriate optimism. At points, it is valuable to allow time and *solicit questions* from the parents as well as let them express their feelings.

Fortunately, most families have many hidden strengths to help them deal with the problems presented by a child with chronic illness. The family can and, in most cases, does arrive at an acceptance of reality; and in an upsurge of positive feeling toward the damaged child, it realizes his potentialities and fastens its hopes on new and attainable goals.

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ASPIRIN POISONING IN CHILDREN

A study of 94 accidental aspirin poisonings in children reveals that in all but one instance the child had been told that the pills were "candy."

Reporting in the July, 1961, issue of AMERICAN JOURNAL OF DISEASES OF CHILDREN, Dr. Roger J. Meyer, of Boston, said, "The entire group of children with but one exception had previous experience with acetylsalicylic acid, usually the flavored variety." This medication was used for virtually *every* illness or indisposition suffered by family members, with or without fever. Parents admitted that they encouraged acceptance by presenting it to children as "candy," and felt that this was an important factor in their children's ingestion of acetylsalicylic acid.

The cases studied involved children from one to five years old and were selected from 313 cases reported to the Boston Poisoning Information Center during a 12-month period.

The study showed that 62 of the children shared the aspirin with playmates, and sweetened aspirin was taken by the youngsters in 84 instances. Of the 94 cases, 73 occurred after aspirin had been used to treat another member of the family and the majority of the poisonings (56.5 per cent) occurred less than an hour before the child's mealtime.

Doctor Meyer said that the predominating circumstances in the homes at the time of the poisoning fell into three categories. In 17 instances aspirin was being used for an illness in the family. In 29 cases, precautions had been taken but the child showed unusual resourcefulness in obtaining the tablets. In 48 cases, there was generally unsatisfactory health supervision or lack of understanding of children's needs.

"All families had a special place for medications, but two factors eliminated this family safeguard: (1) family ignorance concerning the dangers of acetylsalicylic acid, and (2) general lack of safety precautions against household hazards," Doctor Meyer commented.

Aspirin is not only the commonest childhood poison, but its widespread use, its attractive taste —at least in tablets prepared especially for children—and the late appearance of its toxic symptoms make it a particular threat to families with young children.—*Iowa State Medical Journal*, August 1961, p. 514.

HIGHLIGHTS OF A SYMPOSIUM PRESENTED BEFORE THE STATE MEDICAL SOCIETY OF WISCONSIN

How Can You Help Parents and Children?

I. Mental Hygiene and Our Children

By CARL L. KLINE, M. D.
Wausau, Wisconsin

Last winter the newspapers carried a story about a protest made by a Wisconsin physician against the lack of outdoor recreational areas for children, in particular for sledding.

This citizen actually was voicing a complaint against a grave social evil of our times of which the lack of coasting places is just one symptom. There is in truth little or no place for kids these days. Children are aware of this and are bewildered and puzzled by it. They just are not wanted any place. Yet they are told how important they are and how much we love them. At the same time they are scolded about the high incidence of juvenile delinquency and are repeatedly cautioned to stay out of trouble.

In the available recreational areas they often are hemmed in by strict rules that detract from the fun of the outing. Regimentation is not compatible with relaxation and fun; play should be free and spontaneous. Even at school some teachers make life miserable for individual children or even entire classes.

Children are frightened and bewildered by the terrifying news reports of engines of destruction developing in our arms race with the Russians. It is time that we understand the effect upon our children of this unholy behavior of the adults of the world.

The nuclear bomb threat is not the only cold war evil that adversely affects our children. Consider the atmosphere of suspicion and hatred which we have created. When our own government tells big lies, how can we impress upon our children the importance of the truth? When we let millions of children starve at the same time that we are storing millions of tons of excess food, how can we talk to our children about kindness and love?

As a nation we are sanctioning immorality by our way of life. The violence on the television screen must seem like a mild game to children who are exposed daily to the threat of a Russian bomb. At the same time they hear how we are preparing to rain the same kind of horrible death upon our fellowmen in Russia. It is not difficult to picture the concept our children are getting of all of us who behave so violently. How puzzled they must be when we tell them they must not fight or get angry. "Be good kiddies and don't disturb us while we are installing the machine gun in our fallout shelter."

Often the personnel in our hospitals are guilty of mistreating children. Nurses are sometimes irritable, impatient, abrupt and lacking in understanding. Often the physician, in his concern over the disease, fails to be warmly sympathetic in his treatment of the child. Often children are whisked away to surgery with no explanation about what is going to happen to them. Sometimes a child is told lies which, when revealed by subsequent events, tend to create fear and distrust.

Even a child with a reasonably good home situation is likely to be adversely affected by these distressing incongruities. Defects in parents are not always the cause of emotional problems in children. All serious threats to a child's basic freedom and security contribute to the formation of emotional problems. Many of these can be avoided. Here is a real practical mental hygiene challenge. These problems should be faced with incentive, initiative, and courage to act.

Presented at the annual meeting of the State Medical Society, May 8, 1962, Milwaukee.

II. Dealing with Parental Anxieties as a Reflection of Children's Behavior

By RAYMOND HEADLEE, M. D.
Milwaukee, Wisconsin

I would like to relate my experience with three children referred to me because of severely disturbed behavior. After careful investigation and treatment of the parents only, the child's problem in each instance, was markedly reduced.

The first situation involved a 12-year-old girl whose problems were in the sexual sphere. She wore excessive makeup, adopted seductive mannerisms, and frequently exposed herself to older men. Discussions with the mother brought to light her own unbalanced sexual feelings. She could not accept the evidence that her daughter was maturing physically and experiencing sexual feelings. Whenever the mother happened to discover the child reacting in the usual way to these sensations, the mother became frightened, but hid her fright behind a display of anger at the child. She would burst into tears and call her husband at work. Treatment of the mother resulted in a satisfactory resolution of the child's struggle.

The second child, a 7-year-old boy, son of a well-to-do business man, was seen first by a pediatrician, then by a child psychiatrist, because of a school problem. The boy had an almost complete blockage of learning process, particularly in the verbal skills, although both parents were highly intelligent and verbal people. Here we were dealing with a mother who out of her feelings of guilt, a strong desire to please her husband, and her wish to have the child become perfect evidenced extreme agitation, fright and anger, whenever the child would make the slightest mistake. One mistake compounded others and soon the boy would be unable to perform at all. The father refused treatment but the mother cooperated. Aided by an understanding school administration, over a three-year period, the boy, though having lost one class in school, is up to the level of learning and reading in the class behind the one in which he belongs. No therapy was given to the boy.

The third problem was presented by a 15-year-old boy who was in serious trouble with his private school authorities for aggressive acting out. His previous record was good. Before seeing the boy, I arranged to see his parents individually. Out of several conferences emerged the information that the boy's mother, in the midst of an illicit love affair, had become extremely agitated and tense at home. She was unable to handle the ordinary problems of an adolescent boy. Added to her feelings of guilt and shame, her intense need for the affair caused her personality to disorganize. The boy's abnormal school behavior was a reflection of his mother's disturbance. I advised both parents that for a while I would like to work only with the mother and see if this would allow the boy to change. I kept in touch with the school counselor, a psychologist, over a period of a year while seeing the mother regularly. The father was referred to another psychiatrist for study of his part in this unfortunate story. Treatment is continuing. The school administrators have made no complaints for several months and the boy has returned to his usual level of work. While the marital situation is not yet resolved, the tensions surrounding it are certainly lessened.

These case reports serve to remind us once more of two basic principles:

First, that many of the patients brought to us for help are caught in a family situation in which another member of the family may be more malignantly ill than the one who comes to us. Here, treatment of this other person, by removing the cause, is more likely to relieve the whole situation, whereas therapeutic efforts directed towards the one whose symptoms are the most conspicuous or produce the most obvious discomfort will yield less than satisfactory results.

Second, that another member of the family may be more accessible to treatment than the patient. Working with the one who can accept help and respond to it often will pave the way for a later effective therapeutic approach to those who at the start are blocked for one reason or another. Sometimes it has been observed in such families that after a year or so the more obviously sick persons will demand for themselves some of that which they have seen happen to the treated person.

I would like also to point out that the mechanics of psychiatric treatment of a child may serve to delay favorable response. Too intense scrutiny of a child who is acting out or withdrawn; over-involvement in psychiatric testing; two trips a week downtown to the psychiatrist with everybody in school knowing about it; and even the intensive psychological treatment in itself, can contribute to a fixation of the symptoms or an exaggeration of the troubles that are already severe.

It is my plea, then, that careful consideration be given to the entire pattern and that we be wary lest we too quickly or too strongly probe a problem in one member of a family at the insistence of another member of the family. Let us use our own judgment.

III. Explaining Parents' Behavior to Children

By HAROLD F. BORENZ, M. D.
Madison, Wisconsin

Separation from his parents at age 1½ years may cause the child to display anaclitic depressive phenomena, whereas in a child at age 4 separation from his parents more commonly produces feelings of responsibility and guilt. Children frequently become convinced that many types of parental behavior are in some way caused by the child himself. A child separated from his parents will, in the majority of instances, blame himself for being rejected. He sees himself as a bad or unloved child because of some relatively unimportant misdeed. This leads to further lowering of self-esteem and interferes with development of satisfactory relationships with parental surrogates.

In children the depressive syndrome manifests itself differently from the way it does in adults. In a child it is seen as sullenness, distant relationship with others, lack of interest, poor school performance, and a day-dreaming attitude with occasional irritability, all too often called laziness by the adults caring for the child. Recognition of the condition by the physician, reassuring the child, and helping the parents understand are important phases of treatment.

Children are only too aware of their dependency state. Without the parents the uncertainty of meeting such basic needs as food, shelter and even getting from one place to another is a serious threat to the child's security. Adults are frequently unaware of the intensity of the child's feeling thus generated. The child imputes great power to the parents. This frequently leads to exaggerated expectation from the parents and accentuates the child's own feeling of weakness and helplessness. Suggestions to the child for trials of self-expression through verbal expression is often very helpful.

Another common area of conflict is related to discipline. Superficially the difficulty may appear as the child's rebellion against parental standards. However, careful study often will reveal that the child is not rebelling but is reacting to a feeling of being hurt because he sees in the disciplinary measures evidence his parents do not love him and are rejecting him. As the child misinterprets parents' behavior, so the parents do not understand the basic feeling of the child. Helping the child to share his feelings about the parents often can lead to an improved communication between parents and child.

Principles

1. The intensity of the child's relationship with the disturbed parents determines whether or not the child can view objectively the abnormality of the parent's behavior.

2. The child can view parental psychopathology only after or in conjunction with a moderately stable and significantly protective relationship with an adult.

3. The behavior of overtly rejecting and depriving parents may be so obvious that the child is less seriously affected than in those cases where the disturbed interaction is more subtle.

4. Accurate knowledge of the child's perception of the parental psychopathology is vital to establishing recommendations for helping the child. This can come about,

sometimes, by description of the child's behavior from another person but in the majority of cases, requires some first-hand contact with the child.

5. In the neurotic parent-child situation, there often cannot be significant changes in the child's misconception unless the parents participate in counselling aimed at helping them understand the childhood distortions of the parent attitudes and the child's own distortion regarding himself.

6. A useful technique is a lengthy conference with the parents after the evaluation of parents and child is complete. In this, the child, as a person with all his feelings, self-perception, goals, fears, is presented to the parents as seen through the eyes of the psychiatrist. The parents have an opportunity to match their view of the child with those of the evaluating psychiatrist and to determine where their misconceptions are and to work toward trying to alter them.

7. At the end of the evaluation of the child, while continuing on therapy, the psychiatrist is in a position to help the child see the parents in a clearer light by raising such questions as why does the child think the parents behave the way they do. It is often surprising how capable and understanding children can be about their parents' life experience, their attitudes and behavior and their anxiety for their child. Bringing the parents into focus as people with problems and not as invincible, omnipotent people, is often corrective for the child.

Few parents truly grasp the child's view of himself and his view of the world about him. His great dependency state, his view of the omnipotence of adults and his misconception of his impact upon and ability to influence parents are a part of the vulnerability of the childhood state. Matched with this are the child's often clearer perception of parent weaknesses when they want to use them and the ever present ability of the child to evoke in the parents powerful feelings of kindness, self-sacrifice, depths of despair over his failures and heights of elation at his successes. We can help the child perceive all of these more clearly as he relates to his parents.

IV. The Value of Diagnosis When No Treatment Resource is Available

By ROBERT E. O'CONNOR
Madison, Wisconsin

The value of diagnosis in the absence of formal treatment resources is a matter of deep concern to all of us who work at a diagnostic center. Since we see children referred to us because of emotional problems return to communities that lack clinics or other psychiatric resources, we often wonder about the value of our services. A review of our experiences has shown that our work, even though limited to diagnosis, often is of direct therapeutic importance to this group of patients.

The diagnosis begins with a referral to the psychiatrist. This in itself is a significant event. The decision to accept psychiatric help, once made, brings about a change in attitude toward the problem on the part of the patient as well as his parents. The parents begin to think in terms of a medical situation instead of a display of good or bad behavior they found challenging or disturbing. While previously they reacted with frustration, they now are subject to a new set of feelings, such as fear or guilt or optimism. The changes within the parents' attitudes can then lead to changes within the family inter-relationships which have long-run effects, desirable or undesirable. However, the very fact of change is important because when it occurs the opportunities for helping the family become greatly enhanced.

After the referral comes the diagnostic process. As this develops the patient is not merely the passive object of observation but becomes actively involved in the diagnostic procedures.

The diagnosis is a dynamic process which in a sense is never complete. The more thorough the study, the more involved the patient becomes in self-appraisal. As the patient works on understanding and communicating his problems to the doctor, he develops a greater degree of self-understanding.

In the diagnosis, the strengths of the patient as well as the weaknesses, his needs and his conflicts, must all be evaluated and communicated either to the patient or to adults responsible for his care. If this communication is done properly and meaningfully, it can have an effect on how the needs of the patient are met. The ways in which adults will deal with his behavior and the ways in which relationships will be worked out between the child and adult can be modified as a result of meaningful communication arising from the diagnostic study.

Some of the problems can be resolved as soon as the diagnosis is made. Recognition by the patient and his parents may be all that is needed. We may be dealing with a transient problem in relation to some traumatic situation in a child who is essentially healthy. Or, the difficulty may be related to a highly disturbing environment from which the child must be removed. He can then be placed in a setting where the disturbing factors are less intense, and where he can find supports that will permit him to develop for a time in close relationship to helpful adults before treatment is undertaken.

What are some of the nonmedical treatment resources which might be available to children?

The first is his family. Increased understanding on the part of the parents can help them to deal with their child's disturbed feelings and behavior. Support to the parents can help them feel less inadequate or less frightened at the child's behavior or of their own reactions to the child. Lessening of anxiety and confusion on the part of the parents toward the child can often allow the child more room to grow, more room to express himself, and more opportunity to resolve conflicts within himself.

The second nonmedical treatment resource is the social agency. Social workers are being given more responsibility for the care of children in community agencies and in institutions. It is the responsibility of psychiatrists to help these people work more effectively with the children.

The social worker can give support, help, and direction to the child and to the parents, either in their relationship to the child or in resolving their own family and social problems that have an indirect effect on the child. Social agencies, particularly those connected with welfare departments or courts, have the authority and the resources to carry out necessary environmental changes.

The third nonmedical treatment resource is the school. The environment of the school parallels that of the home in importance to the child. Teachers have responsibilities similar to those of parents and social workers. Often in the classroom they recognize the child's need for help but are frustrated because they do not understand the child's behavior or because they feel misunderstood or undervalued in the community. If we can understand the problems of the teacher, whether it be the problem of attempting to maintain order in a large classroom with one child who is impervious to their disciplinary attempts, or the problem of making their difficulties and anxieties understood by others outside of the teaching profession, and if we can "talk the language of the teachers," we can have an influence on the course of the child in the school. Very often children who are disturbed in every other situation find that the school is one area where they can gain recognition. All of us are familiar with situations where all other factors being negative the positive values of the school have been communicated to the child and have been his salvation.

Even though formal treatment resources in Wisconsin are limited, understanding the child's problems through a diagnostic study can lead to constructive therapy by nonmedical agencies.

PRICELESS INGREDIENT OF QUALITY

Notwithstanding all of the regulations and standards of the present official and semi-official bodies and agencies charged with the responsibility of controlling the quality of drugs, the only way the average physician and the average hospital can judge the quality of the drugs they use is by their reliance on the reputation of the name of the manufacturer, which appears on the label.—JOSEPH E. SNYDER, M.D., Assistant Vice-President, New York Presbyterian Hospital, to American Hospital Association.

CASE REPORT

Appendicitis in a One-Year-Old Child

By J. F. MARCH, M. D.
Algoma, Wiscansin

REPORTED CASES of the diagnosis of appendicitis in a child under the age of two years are unusual. Several surgeons in the state were consulted and each reported that in the past 10 years he had seen only one case of appendicitis in a child under the age of two years.

This case is being reported because the diagnosis was made before surgery and because the age of the child was one year. During the past 10 years in a rural general practice, we have seen one other child under one year of age with appendicitis.

A one-year-old infant was seen in the office in December, 1961. The child had a history of "flu" for the preceding three or four days. This consisted of diarrhea and some vomiting. The child appeared to be somewhat toxic. He was dehydrated and had been running a fever for 36 hours. The mother stated that she believed the child's pain was of a colicky nature because the child cried at intervals.

From the Algoma Clinic.

On examination of the abdomen, the liver and spleen were not enlarged. There was no tenderness in the left side of the abdomen, but there was marked tenderness in the right lower quadrant with rebound tenderness also present. The blood cell count at this time showed a hemoglobin level of 9.4 gm. per 100 ml., red blood cell count of 3,260,000 and a white blood cell count of 22,650. The child was hospitalized and an appendectomy performed. The pathologic diagnosis was acute necrotizing appendicitis. Two days later the white blood cell count was 9,650.

The child had chicken pox two weeks prior to the attack. It is interesting to speculate upon the possibility of some relationship between chicken pox and appendicitis.

This case is presented because of the unusual age, the correct preoperative diagnosis of appendicitis, and the chicken pox preceding it.

FAILURE OF CLOSED CHEST CARDIAC MASSAGE TO PRODUCE PULMONARY VENTILATION

SAFAR, P., BROWN, T. C., and HOLTEY, W. J., *Dis. Chest* 41:1 (Jan.) 1962.

"Most patients in need of closed chest cardiac massage are not only pulseless, but also apneic. It is imperative to provide adequate pulmonary ventilation during the performance of sternal pressure since circulation of unoxygenated blood would be senseless. Unfortunately, published illustrations of closed chest cardiac massage have shown only a single operator compressing the sternum without a second operator providing a patent airway and intermittent inflation of the lungs . . . It seemed indicated to study the amount of ventilation produced by sternal pressure."

The authors summarize their finds as follows:

"(1) Rhythmic sternal pressure produced no tidal exchange in 30 curarized adults with a natural airway and the head unsupported, since lack of backward tilt of the head caused hypopharngeal obstruction by the tongue. Even when the shoulders were elevated, in order to make the head assume a backward tilt, sternal compressions produced no tidal exchange in 16 of 30 subjects.

"(2) With a tracheal tube by-passing the upper airway obstruction, sternal compression produced an average tidal volume of 156 ml. (0 to 390 ml.).

"(3) In patients with cardiac arrest closed chest cardiac massage produced no tidal exchange even with the use of a tracheal tube, while intermittent positive pressure ventilation produced tidal volumes of over 1,000 ml.

"(4) Rhythmic sternal compression failed to reoxygenate five of six hypoxic curarized adults.

"(5) Closed chest cardiac massage should be accompanied by positive pressure ventilation of the lungs. One of several possible combinations consists of following each lung inflation by four sternal compressions, at one second intervals.

Adenotonsillectomy in Children

A Review of Current Medical Reports

By JOHN R. LARSEN, M. D.
and MAXINE BENNETT, M. D.
Madison, Wisconsin

THE SUBJECT of adenotonsillectomy has received considerable attention in the medical literature. A review of the more recent and interesting articles has been made and an attempted organization of the subject material is presented. The statements made may not always represent the opinions of the reviewers.

INTRODUCTION

Over two million tonsillectomies are done in the United States each year.[1] The annual toll of 300 deaths associated with the procedure dramatizes the fact that this is not minor, office surgery, but surgery which should be approached with care by an adequately trained surgeon, whether he is a general practitioner or an otolaryngologist. This deceptively simple operation is a vast economic and health problem which is still not completely solved even though it has been performed for over 3,000 years.

The management of tonsil, adenoid and related problems is a controversial subject which is important to the patient and his parents, hospital personnel, the family physician and pediatrician as well as the otolaryngologist. Inattentiveness has often led to improper indications for surgery, inadequate preoperative preparation, imperfect surgical technique and negligent follow-up. Needless operations and complications have caused some even to ask the question: "Is the removal of tonsils and adenoids necessary?"[2] However, the removal of a diseased organ is a basic procedure in the surgical treatment of disease anywhere in the body, and most people concerned with the problem agree that adenotonsillectomy is a useful operation when it is done for the proper indications and done well.

ANATOMY

The entire respiratory tract is lined with a continuous epithelial surface; and diseases of the ear, nose, throat and lung are usually interrelated. The lymphoid tissue of the throat forms a complete ring, described by Waldeyer, which includes the faucial tonsils, the lingual tonsils, the adenoids and the lymphoid tissue of Rosenmuller's fossa. In addition, lymphoid tissue is present in the wall of the Eustachian tube, and this is called the tubal tonsil of Gerlach. The faucial tonsil is unique in that it has extensive crypt formation. The bases of the crypts usually rest on the capsule of the tonsil[3] and are filled with debris, such as food particles, mucus, desquamated epithelial cells, leukocytes and bacteria. The nasopharynx in infants is unusually small, and even moderate enlargement of the adenoids can be obstructive. The anatomic details and relationships are extremely important to the surgeon and are available in any textbook of anatomy.

PHYSIOLOGY

It was formerly believed that the lymphoid tissue of the throat had no function. It is now known that this tissue functions in the immunologic mechanisms of the growing child by making initial contact with bacteria and other antigens, thus sensitizing the entire reticuloendothelial system and stimulating the production of antibodies.[4] Lymphoid tissue often, but not always atrophies with increasing age. Starvation, systemic cortisone or corticotropin (ACTH), radiation, nitrogen mustard and other toxic substances cause a reduction in the size of lymphoid tissue. Infection, allergy, overfeeding and hormone deficiency cause an increase in the size of lymphoid tissue.

PATHOLOGY

Hyperplasia may be seen with or without infection. The chronically infected tonsil is usually scarred down rather than markedly enlarged. Acute or chronic infection results from contact with microorganisms introduced through breathing, eating or drinking. Extension of the infection may result in inflammation or suppuration of regional lymph nodes.[1] Systemic disease may be produced by microorganisms or toxins gaining

entrance to the blood stream and also by special allergic reactions as in rheumatic fever or glomerulonephritis. Enlargement of the tonsils or adenoids may interfere with breathing, swallowing and Eustachian tube ventilation. Secretory otitis media is a common result of Eustachian tubal obstruction by hypertrophic adenoids. Recurring infections of the nose, paranasal sinuses and lower respiratory tract are commonly associated with chronic disease of the tonsils and adenoids.

CLINICAL PICTURE AND DIAGNOSIS

The symptoms attributed to diseased adenoids are legion, and include: nasal obstruction, snuffling, purulent or mucopurulent nasal or postnasal discharge, poor sense of smell, snoring, noisy respirations, absence of nasal resonance, frequent head colds, bronchitis, croup, facial deformity, crooked teeth, mental dullness, sinus trouble, disturbed sleep and night terrors, defective growth, inability to fix the attention, neuroses, fetid breath, cervical lymph adenitis, gastrointestinal disturbances and systemic infections. The symptoms related to the ear are particularly important and include: hearing impairment, earaches, running ears and mastoiditis.

Diseased tonsils may produce some of the above symptoms and also recurrent sore throats and mechanical obstruction to swallowing. Since tonsils and adenoids are commonly involved together, symptoms overlap.

Examination of the nasopharynx may be difficult in young children and general anesthesia is accepted as a diagnostic measure when symptoms warrant. Palpation of the nasopharynx may be psychologically traumatic, but is valuable. When disease is present, the examining finger will be covered with tenacious mucus streaked with blood. Posterior rhinoscopy and nasopharyngoscopy may be done in older, cooperative children. The extent of adenoid hypertrophy "can be determined by the extent to which the posterior nasal septum is hidden from view in the mirror."[5] With minimal hypertrophy, only the upper portion will be hidden, while "with extreme hypertrophy, the entire septum is invisible."[5]

Examination of the ear should be done carefully, and include an evaluation of hearing, preferably pure-tone audiometry. The dull, bluish or yellowish, retracted ear drum and associated conduction deafness are well known signs of secretory otitis media.

Roentgenography of the nasopharynx has been used infrequently in children for the diagnosis of adenoid hypertrophy, but it is a simple, nontraumatic and accurate method of determining the size, shape and position of enlarged adenoids.[6]

EVALUATION FOR SURGERY

General Considerations

In the past, indications have been too liberal. When a long waiting list forces a delay before operation, many operations are cancelled because symptoms have vanished.[7] There is no emergency for tonsil and adenoid surgery. In evaluating the individual case, it is wise to be as certain as possible that symptoms are due to the tonsils or adenoids.

Indications for Adenoidectomy

When the adenoids produce symptoms and impair health, they should be removed. The amount of tissue is not always proportional to the amount of morbidity. Auditory symptoms may be produced by small amounts of strategically located adenoid tissue, and they constitute the most urgent group of indications for adenoidectomy. Any of the symptoms definitely caused by diseased adenoid can be an indication for adenoidectomy, but a period of judicious observation is usually recommended.

Indications for Tonsillectomy

The appearance of the tonsils is usually the least important factor in determining whether surgery is indicated. Frequent attacks of the common cold are not an indication for tonsillectomy, but residual infection after acute streptococcal tonsillitis or recurrent tonsillitis is an indication, especially when there is a history of rheumatic fever or nephritis in the patient or his family. Peritonsillar abscess is an indication for tonsillectomy. Bateman[8] has recommended tonsillectomy for the acute phase, but most authorities prefer merely to incise the abscess and do the tonsillectomy after the acute process has subsided. Other indications for tonsillectomy include: cervical gland enlargement, focus of infection, foul breath, local irritation, suspicion of neoplasm, and hypertrophy to the extent of obstruction.

CONTRAINDICATIONS TO SURGERY

Relative contraindications to surgery include: blood dyscrasias; acute or uncontrolled systemic disease such as diabetes, nephritis or rheumatic fever; general debility or anemia. Age, poliomyelitis epidemics, allergy and cleft palate patients are separate problems which may be relative contraindications or modifying factors in proposed surgery.

Age

In general, the younger the child and the fewer the complaints, the more reluctant one should be to resort to surgery. There is considerable difference of opinion and little concrete evidence on this subject. Some feel that adenoidectomy can be done from infancy on, but that tonsillectomy should be delayed to age four or five. Others feel that adenoidectomy should not be done before age three because of the probability of recurrence. At University Hospitals it is rarely found necessary to do either procedure before three years of age, but the indications may necessitate surgery before one year of age.

Poliomyelitis

The attack rate of poliomyelitis following adenotonsillectomy is less than that in the general population, but if poliomyelitis does occur, the incidence of the bulbar type is increased. The use of vaccine has to a large extent made the operation less seasonal, but some authorities are still wary of doing the operation during the summer months even in immunized patients. Sabin[9] feels that the operation may be done if the patient has had a booster injection within two weeks of the procedure.

Allergy

The allergic child presents a complicated problem when diseased tonsils and adenoids enter the picture.[10,11] The patient with allergy or strong family history of allergy should not be considered for operation during the pollen season because he may be sensitized to pollen. Proper allergic management, including desensitization and the avoidance of allergens, is essential if the maximum benefit is to be derived from adenotonsillectomy. Tonsils and adenoids may act as a focus of infection to which bacterial allergy can develop in a potentially asthmatic patient. On the other hand, removal of tonsils and adenoids may precipitate asthma or increase symptoms. The indications for adenotonsillectomy are the same in allergic and nonallergic patients, but the physician should be more conservative in the allergic patient. It is probable that any child who requires adenotonsillectomy before the age of three years, or any child who requires a second operation, is an allergic child.

Cleft Palate

Another complicated problem is the patient with cleft palate and diseased tonsils and adenoids. Nearly all patients with cleft palate have hearing loss detectable by audiometry.[12] The conductive loss is probably related to the altered Eustachian tubal physiology caused by defective insertions of the tensor and levator palati. Failure of the tubal orifices to open may lead to secretory otitis media. Abnormal reflux of food and fluid into the nasal cavity may also set up chronic inflammatory changes around the tubal orifices with obstruction by hypertrophic lateral adenoid bands. "Good hearing is essential to good speech,"[13] and the rehabilitation program must consider hearing problems as well as speech problems. Adenoid masses may allow normal speech by providing a pad against which the short palate can close, and removal in these instances may lead to a series of adjustment problems for the patient.[14] Lateral bandectomy alone has not proven effective in the treatment of conductive deafness in these patients.[15] No definite answer can be given at this time, but it seems that early restoration of dynamic tubal physiology combined with continuous otological study may be the best method for controlling the appalling incidence of hearing loss. It is generally agreed that tonsillectomy is best deferred until age six or seven years, if possible, because a certain amount of scarring is inevitable even with careful technique. Contraction of this scar tissue will impair the speech and the function of the palate in deglutition to a certain degree. Close cooperation is essential between the otolaryngologist, plastic surgeon, and speech therapist in order to obtain optimum results.

CHOICE OF PROCEDURE

Adenoidectomy is of the first importance in most cases for which adenotonsillectomy is indicated, and some authorities recom-

mend adenoidectomy without tonsillectomy unless specific indications exist for tonsillectomy.[16]

There is an increasing trend toward treating concurrent disease of the ear and sinuses surgically at the time of adenotonsillectomy by myringotomy or antral lavage.[17] Proctor,[1] however, feels that most cases of serous otitis will return to normal following adenoidectomy and that routine myringotomy should not be done.

PREOPERATIVE MANAGEMENT

A careful medical evaluation, including chest x-ray studies, should be made before hospitalization.[10] Nutrition should be optimum, and some recommend routine use of vitamins preoperatively for several weeks. The existence of the following conditions should be considered and corrected, if present: anemia, hypothyroidism, intestinal parasites, any infections, vasomotor rhinitis, allergy, endocrine disturbances, hypogammaglobulinemia, cystic fibrosis, infectious mononucleosis, and tuberculous adenopathy. Special problems such as epilepsy, congenital or rheumatic heart disease and chronic pulmonary disease should receive special preoperative treatment, such as increased anticonvulsants or antibiotics.

The preoperative detection and prevention of bleeding tendencies is a special problem. Many feel that the history of bleeding tendency is the most important factor, and that routine bleeding and coagulation times are wasteful and unnecessary. Others feel that the history is not decisive, especially since this is likely to be the first surgery that the patient has. Mayer and MacPherson[18] recommend routine platelet count or clot retraction test, capillary fragility, and standard clotting time to screen out all possible bleeders. Specific defects such as increased capillary fragility or prolonged coagulation time should be investigated and treated properly. Most investigators feel that routine preoperative use of vitamin K, vitamin C, antibiotics, and systemic hemostatic agents is neither effective nor indicated. Other investigators[19,20] attribute much of their success in preventing bleeding to rigid preoperative programs including all possible empirical measures.

Psychologic considerations in treatment of the pediatric patient have received attention.[10,21] The child should not be hurt during examination if at all possible. The child should be told what to expect in terms that he can understand, and he should never be told a lie. One student nurse[22] was so impressed with this problem that she designed a coloring book depicting hospital scenes. The book is now routinely given to children on admission for their adenotonsillectomy. The parents should be told why the operation is necessary and what to expect so that they can be more confident in dealing with the situation. A printed preoperative instruction sheet has proved valuable. Although the impact of hospitalization may be damaging, most children need only friendly, considerate courtesy and explanation. No amount of hurried preparation will change the fearful behavior pattern of an emotionally disturbed child, and psychiatric guidance is needed in these cases.

MANAGEMENT OF THE OPERATION

The aim of the adenotonsillectomy is clean removal of the diseased tissue with a minimum of trauma. There are infinite technical variations and modifications, and each operator should strive to develop a technique that for him is effective. Difficulties and mistakes are usually due to poor visualization of the operative field resulting from incorrect positioning of the patient and surgeon, and from poor anesthetic techniques.[23] There is no unanimity regarding position, but the recumbent, Trendelenberg position with the patient's head slightly flexed seems favored over the head down and extended position.

Anesthesia

The classical method of general anesthesia for tonsillectomy has been open drop ether followed by insufflation into the open mouth without intubation. With this technique, deep anesthesia is needed for relaxation, and a certain amount of blood and mucus is aspirated into the lungs even with constant attention to the airway. When skilled anesthesiologists are available, the use of an endotracheal tube has been widely adopted for the maintenance of a positive airway. Most surgeons will accept the nuisance of a tube in the mouth and the risk of laryngeal edema because the patient is relaxed and the airway not so much a constant problem. A considerable amount of experimenting is being done with various combinations of

agents and premedicating drugs[24] including: nitrous oxide, vinyl ether, promethazine (Phenergan), pentobarbital, rectal thiopental sodium (Pentothal), halothane (Fluothane), and muscle relaxants. So far, no clearly superior technique has emerged.

Technique of Tonsillectomy

Countless instruments have been devised for this procedure including special mouth gags with lights, tongue blades and airways attached. The dissection and snare techniques continue to be the operation of choice in most centers. Emerson[25] has described a technique for closed fossa tonsillectomy and plastic repair of the mucous membrane, but this has not been widely adopted. Guillotine tonsillectomy has received unfavorable criticism, but skillful use combined with separate removal of the plica supratonsillaris and the plica triangularia can be a rapid and efficient method in selected cases.

Technique of Adenoidectomy

The standard technique of palpation, La-Force adenotome, curette and biting forceps is generally used, although there are many variations. Some favor the use of palpation as an aid in the removal of tissue and others favor operating under direct vision exclusively. The important tissue around the Eustachian tube orifice may be left behind if the operation is not done with care. Sometimes a Eustachian tube catheter is placed to protect the orifice. The Yankauer speculum may be used to aid in exposure of the nasopharynx. Alexander[5] has recommended a horizontal incision immediately below the adenoid mass before using the curette in order to prevent stripping of the nasopharyngeal mucosa as the curette is removed. Houlihan[26] has advocated a different approach to adenoidectomy, and claims that the incidence of bleeding can be greatly reduced by a technique using a small curved curette and avoiding the adenotome. He bases the technique on the anatomical fact that the adenoids occur as two distinct masses on either side of the midline with the median raphe in between. The insertion of the superior constrictor muscle into the exposed pharyngeal tubercle is often injured by the adenotome with resultant postoperative adenoid bleeding.

Hemostasis

"Careful attention to hemostasis will in almost all instances, prevent hemorrhage within the immediate postoperative period,"[23] thus saving trouble, misery and occasionally a life. Techniques include: ligature with simple, slip or square knot and suture ligature; temporary packing; suturing the pillars together; contact of the removed tonsil on the adenoid bed; injection of saline submucosally in the nasopharynx. Electrocautery, using halothane anesthesia, has been advocated for the control of operative bleeding.[27,28] The method is rapid and certain, but the incidence of late bleeding of 7 per cent seems high. Most of the bleeding was mild, however, and the technique is improving.

POSTOPERATIVE MANAGEMENT

Immediately following the operation, the patient should be watched carefully for fresh bleeding from the mouth or nose, and an elevated pulse. Hematemesis is common following the procedure and is not important unless it is unusually frequent or copious. The patient should be in a semiprone position. Hypotension, inadequate respirations and disturbing excitation require immediate attention.

Analgesia is usually required for 7 to 10 days following the operation. It is generally agreed that aspirin locally and in high concentrations systemically is associated with postoperative bleeding, although this is not related to the prothrombin time. Codeine, meperidine hydrochloride (Demerol) elixir, acetaminophen, and topical anesthetics such as lidocaine (Xylocaine) viscous, Chloraseptic[29] or tripelennamine (Pyribenzamine) elixir are some recommended substitutes for aspirin. Pentobarbital sodium can be used for sedation, but does not provide analgesia.[30]

Antibiotics are not recommended for routine use by most authors, but some feel that topical or systemic antibiotics are beneficial. Ehrenreich[31] used an antibacterial-analgesic chewing gum troche (Orabiotic) containing gramicidin, neomycin and propesin in a double-blind study. He found that chewing the preparation for 10 to 15 minutes four times a day led to a marked improvement in the appearance of the tonsillar fossa one week postoperatively with associated decrease in painful swallowing, otalgia, malodorous breath and hemorrhage.

The parents should be given written instructions in the home care of the postoperative adenotonsillectomy patient, including information about diet, activity, analgesia, and, in general, what to expect. This will forestall parental anxiety and needless telephone calls, and at the same time enable the parents to know when the physician should be called if complications, such as bleeding, persistent fever, vomiting or cough, should occur.[32]

COMPLICATIONS

Hemorrhage at about one week postoperatively is the most common serious complication of adenotonsillectomy. Systemic hemostatic agents such as carbazochrome salicylate (Adrenosem), conjugated equine estrogens (Premarin) or pituitary hormones (Pituitrin), have been reported to be of value, but many cases will stop bleeding spontaneously, and others will require ligation of a bleeding point, postnasal packing and blood transfusion whether the systemic drugs are given or not.

Other complications are much less common and include: edema of the palate and uvula, acute inflammation with delayed healing, pulmonary foreign bodies (teeth, bits of tissue, blood, sponges, and pieces of instruments), bronchopneumonia, lung abcess, atelectasis, thrombophlebitis, septicemia, otitis media, exacerbation of organic disease, meningitis, and pneumoperitoneum.[33] In recent years, two cases of pneumoperitoneum have been reported from Wisconsin.[34,35] This has been called the "air sucker's gastric rupture syndrome" by Olsen and Foley, and is produced when a relaxed cricopharyngeus muscle allows large amounts of air to be sucked into the stomach during strenuous inspiratory efforts. Rupture of the stomach produces the massive pneumoperitoneum, and requires tapping and usually surgical closure of the defect.

Death occurs in 1 out of 7,100 operations. Forty per cent are due to anesthesia, 30 per cent to immediate postoperative care, and another 30 per cent to hemorrhage.[1]

RESULTS OF SURGERY

Adenoid recurrence causes the production of the original symptoms and occurs fairly frequently. Most adenoid recurrences are due to inadequate surgery in the first place, but allergy, infection and disturbances of physiology may also play important roles. Treatment in most cases is secondary adenoidectomy.[36] Local radium application is seldom used now because of the possibility that it will cause the later development of a malignancy.

Residual tonsil tissue occurs far more frequently than it should and is almost always due to inadequate excision of basilar lymphoid tissue. Treatment, if necessary, may be by dissection or electrocautery.

Considerable controversy exists over the value of adenotonsillectomy. Observations have shown that the incidence of the following complaints is significantly reduced over that of a control group in whom operation had been recommended but not performed: sore throats, cervical adenitis, scarlet fever, diphtheria, deafness, otitis media, and chronic sinusitis.[23]

Close observation of the patient for several years after the procedure is advised if optimum results are to be obtained. Infections and allergies should be treated as they arise to prevent late disease, such as chronic mastoiditis or chronic sinusitis.

SUMMARY

The evidence in recent reports has been evaluated with regard to current opinions on the management of adenotonsillectomy. For optimum results, each patient must be evaluated individually and treated surgically only with the proper indications. With meticulous preoperative, operative and postoperative care, the results of adenotonsillectomy can be expected to be beneficial.

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CHRONIC BRONCHITIS—

An Underrated, Fateful Disease

BANYAI, A. L., *Geriatrics* 17:5 (Jan.) 1962.

"Chronic bronchitis is characterized by frequent diurnal and often nocturnal cough (polybechia)—more than 10 coughing spells in a twenty-four hour period—which originates from an inflammatory process in the lower air passages and persists for several months or longer. It is associated with increased tussive irritability and with variable amount of sputum. The latter is either mucous, mucopurulent, or purulent. There are cyclic variations in its intensity, with alternating remissions and flare-ups. Exertional dyspnea is frequently noted."

Etiology includes chronic alcoholism with malnutrition, atmospheric pollutants (including smoking), occupational inhalants, diabetes, obesity, senescence, chronic liver disease, bronchospasm, microbial agents (most frequently coagulase—positive staphylococcus pyogenes), and virus, particularly influenza A. Sequelae of chronic bronchitis include fibrosis, bronchospasm, atelectasis, periodic fever, pseudohypertrophic emphysema, bronchogenic carcinoma (possibly), pulmonary insufficiency, and corpulmonale.

For diagnosis, physical examination of the chest is indispensable. In addition, laboratory examination of the sputum (including cytologic examination), roentgenograms, and bronchograms are advisable. Treatment is often complex and difficult. It may include antibiotics, measures for cough alleviation, periodic examinations and special measures (including corticosteroids) during flare-ups, and administration of bronchospasmolytic drugs.

Concerning place of oxygen therapy in treatment, the author states: "In cases of distressing dyspnea not amenable to other measures, oxygen is given in gradually increasing concentrations, starting with less than 50 per cent, through a nasal catheter, always with added moisture. High concentrations of oxygen given abruptly are hazardous . . . In some instances of pronounced dyspnea and polybechia, intermittent positive-pressure breathing may be used to advantage. This method not only provides oxygen, which can also be used as a propellant for aerosolized bronchospasmolytic drugs and antimicrobials, but also mechanically dilates the lower air passages and enhances the expulsive force of cough.

Sponsored by Section on Pathology
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CASE PRESENTATION*

The patient was a newborn infant male born six weeks prematurely after a normal delivery in September, 1961. The birth weight was 5 lbs. 4½ oz. Respirations were grunting almost from birth.

Physical examination revealed a well developed infant with grunting-type respirations. Breathing was rapid and shallow with some sternal and intercostal retraction. His color was good but his cry was weak. The abdomen was distended and the intestinal pattern was visible on the abdominal wall. The rectum was patent. No meconium had been passed on the first physical examination. Abdominal tenderness was present although no muscle rigidity was detected. Muscle tone was diminished. The Moro reflex was weak.

X-ray films of the chest and abdomen showed no evidence of pulmonary or cardiovascular abnormality; heart size was normal, and no bony abnormality could be identified. There was gas within the stomach, small intestine and large intestine. Properitoneal flank stripes were present. The intestinal wall was of normal thickness. Impression: negative examination of chest and abdomen.

Farber tests on the day of birth revealed no squamous epithelial cells. Direct Coombs test on the cord blood was negative. The test for syphilis was nonreactive. Blood pH was 7.36, carbon dioxide content was 20.2 mEq./l.

First Day. X-ray reexamination of the abdomen in flat and upright projections showed a definite change with widening of the space between the gas-filled loops of small and large intestine which suggested peritoneal fluid and was compatible with the clinical impression of peritonitis. No free air and no definite evidence of meconium ileus were seen. Farber tests revealed squamous epithelial fragments.

Blood studies revealed a hemoglobin level of 16.5 gm. per 100 ml. with a hematocrit reading of 50%. White blood cell count was 11,250 with 50 segmented neutrophils, 3 band forms, 36 lymphocytes and 3 monocytes. Blood carbon dioxide content equalled 20 mEq./l. or 45 volumes per cent. Chlorides were 99 (579 mg. per 100 ml.), sodium 137, potassium 6.9 and calcium 3.95 mEq./l.

Respirations increased to the range of 100 to 120 per minute. Cyanosis was detected. The abdomen was quite distended. A stomach tube was inserted and air removed along with some bile-stained fluid. Following this the respirations improved and were less labored. The distention appeared less marked. Definite tenderness, which seemed greater on the right side, was present. Treatment with penicillin and chloramphenicol was instituted.

Second Day. Abdominal distention was unchanged. Peristalsis was audible. Respirations were not labored and the lungs were clear. Carbon dioxide content was 24.2, chlorides 102.8, sodium 140 and potassium 7.8 mEq./l.

Third Day. Abdominal distention appeared to be less. The gastric suction was working and dark material was returning. A slight icterus was present. There appeared to be some increased muscular rigidity in the right lower quadrant. Peristalsis was good to auscultation. Blood bilirubin was 11 mg. per 100 ml. Blood culture showed numerous Gram-positive cocci occurring in pairs.

Fourth Day. More frequent and severe episodes of apnea and cyanosis were noted. Respirations were irregular and labored. Examination of the lungs and heart was essentially negative. The abdomen was distended and silent. Carbon dioxide content was 22.6, chlorides 106, sodium 138 and potassium 3.5 mEq./l. Administration of so-

*From Mercy Hospital.

dium dimethoxyphenyl penicillin (Staphcillin) was begun. Further bacteriologic studies of the blood culture revealed the organisms to be coagulase negative staphylococci. The hematocrit reading was 47% and the hemoglobin level was 14.8 gm. per 100 ml.

Sixth Day. The condition of the infant was essentially the same. The blood pH was 7.13, carbon dioxide content 12.1, chlorides 100, sodium 131 and potassium 8.15 mEq. l.; hemoglobin level 13.3 gm. per 100 ml., and hematocrit reading 40%. Throughout the hospital course various electrolyte preparations were given intravenously. The patient's condition continued to deteriorate despite therapy and the patient died on the sixth day. Immediately before death a blood pH of 6.64 and a carbon dioxide content of 13.1 mEq./l. were reported.

DIFFERENTIAL DIAGNOSIS

Dr. John A. Leschke: The problem presented here is that of a premature infant who was ill at the time of birth. The outstanding symptom is the distention of the abdomen. Because this condition is one of the cardinal signs of intestinal obstruction, attention must be focused primarily on this disorder. Constipation and vomiting are as pathognomonic of obstruction in the newborn infant as they are in the adult. However, the time of appearance of these signs and their intensity will vary somewhat depending upon the location and completeness of the obstructing lesion. In attempting to classify various causes of intestinal obstruction in the newborn period, the following method as suggested by Santulli can be used.

I. Mechanical
- A. Congenital
  - (1) Intrinsic
    - (a) atresia
    - (b) stenosis
    - (c) meconium ileus
    - (d) hypertrophic stenosis of pylorus
    - (e) cyst within lumen of intestine
    - (f) imperforate anus
    - (g) rupture of intestine
  - (2) Extrinsic
    - (a) malrotation with or without volvulus
    - (b) volvulus without malrotation
    - (c) congenital bands with or without malrotation
    - (d) incarcerated hernia
    - (e) annular pancreas
    - (f) duplication of stomach or intestine
- B. Acquired causes
  - (1) Intususception
  - (2) Peritoneal adhesions
  - (3) Mesenteric thrombosis
  - (4) Meconium and mucous plugs
  - (5) Paralytic ileus due to enteral infection

II. Functional causes
- A. Defective inervation
- B. Unexplained

Some of these causes of intestinal obstruction were unlikely in our patient's disease. Although atresia and intrinsic stenosis are the most common causes of obstruction, the presence of gas within the stomach, small intestine and large intestine rule this out. Because distention was present at the time of birth—in contrast to that occurring typically during the second 12 hours of life—and without the presence of hard palpable abdominal masses and the absence of gas in the large intestine in addition to the positive Farber's test, there is fair evidence against the possibility of meconium ileus being present. Furthermore, the absence of this evidence was specifically mentioned in the radiologic reports.

With hypertrophic stenosis of the pylorus there should be a later onset associated with usual signs of vomiting, constipation, gastric peristaltic waves and a palpable pyloric tumor. Cysts within the lumen of the intestine are extremely rare conditions in newborn infants. X-ray studies and the sudden onset of the patient's obstruction would probably rule this out.

Considering imperforate anus, the rectal examination showed the anus to be patent. Malrotation with or without midintestinal volvulus can occur at the time of birth, but usually the early cases occur about the third or fourth day. Furthermore, abdominal x-ray films again showed air in the entire small and large intestine. There was no mention of the presence of an umbilical or

inguinal hernia, and a diaphragmatic hernia should have been seen on the chest x-ray film. With an incarcerated internal hernia, which is extremely rare, gas should not have been present in the large intestine.

Annular pancreas would show signs and symptoms of a high obstructing lesion for which there is no evidence in the protocol. Considering duplications of the stomach or intestine, typically there should be found air-filled cysts on the abdominal x-ray films if these structural anomalies communicated with the intestinal lumen. If they do not communicate or are not filled with air, their presence might be suspected by solid masses distorting the normal intestinal pattern. Many times they will cause signs of partial intestinal obstruction.

Intusussception is very rare during the first month of life and is usually associated with vomiting and a palpable abdominal mass plus blood in the stool. Abdominal distention usually appears later. Peritoneal adhesions can also cause intestinal obstruction but again a more distinct locus would be present on the abdominal films. Mesenteric thrombosis has been thought to cause intestinal obstruction slowly and usually follows an illness in the patient. Distention usually occurs late. Paralytic ileus has on a few occasions followed enteral infection due to Pseudomonas aeruginosa, but the ileus appeared a few days after the diarrhea began. Many times the stools are bright green in color and the ileus itself is not complete. In reviewing the protocol it was not noted whether a stool was actually passed but only that a positive Farber's test was obtained.

There are now remaining a few causes of intestinal obstruction which seem more likely with regard to this patient. The diagnosis of Hirschsprung's disease, or congenital megacolon, in the newborn period is much more difficult to make because of the absence of the characteristic features found in older infants. Vomiting may be delayed until after the first few days of life, distention is variable, and it is possible for a few meconium stools to be passed before the appearance of constipation.

Our x-ray findings coincided with those found in newborn infants having Hirschsprung's disease; that is, distended loops of intestines throughout the abdomen in which large and small bowel patterns could be identified. Furthermore, no localized area of complete obstruction is noted in Hirschsprung's disease, and this is what was generally found in our films. However, the sequence of events typically is not as sudden as it was in our patient, and the disease is more intermittent in nature.

A number of investigators have reported a condition which has sometimes been called the meconial plug syndrome in which a hard meconium mass is the obstructing factor. It has appeared in patients in whom neither a ganglion cell abnormality or enzyme deficiency was noted. However, usually no meconium stools were present although some mucoid-like material was passed in a few of the patients. The x-ray findings of this condition are also similar to those reported in the protocol. In a number of reported cases digital examination of the rectum resulted in the passage of a firm meconium mass. Following this the symptoms subsided. In others the firm meconium stool was demonstrated at the time of surgery.

Another one of the conditions which resembles the problem presented here is obstruction of the intestine due to bowel rupture. However, rupture of the bowel usually follows dilatation of intestines due to a definite obstructing lesion; the rupture then would occur proximal to the point of obstruction. Nevertheless a number of cases have been reported in which the intestinal wall had ruptured and later examination showed that there were areas which were congenitally weak or thin and with no evidence of ulceration or infection being present. These conditions should be kept in mind as distinct possibilities.

From the protocol it should be noted that on the second day of life the condition of our patient was worse. Increased abdominal distention, more rapid respirations and cyanosis were noted. Furthermore, the radiologist mentioned that there was a definite change in the abdominal x-ray films which now suggested the presence of peritoneal fluid and was compatible with a clinical impression of peritonitis.

Although peritonitis is a common complication following some of the causes of intestinal obstruction which have been previously mentioned, it may be worthwhile to classify causes of peritonitis in the newborn period and to mention other possible

mechanisms resulting in this condition. Rickham suggests the following classification.

I. Meconium peritonitis
   A. Group I (with intestinal obstruction)
      (1) In lumen of intestine
      (2) In wall of intestine
      (3) Outside the intestine
   B. Group II (without intestinal obstruction)
      (1) Defect in muscularis
      (2) Vascular accident
      (3) Hypertrophy of glands of Lieberkühn

II. Acute bacterial peritonitis
   A. Acute appendicitis
   B. Perforated Meckel's diverticulum
   C. Perforated ulcer
   D. Perforated intestine
   E. Gangrenous intestine
   F. Trauma
   G. Septicemia
   H. Infected pneumoperitoneum
   I. Transmural infection from gastroenteritis

III. Bile peritonitis

It may seem that this classification is not a great aid in clarifying the problem or indicating a definite diagnosis. Perhaps the reason for this is that peritonitis in the newborn infant may be secondary to a large number of primary disorders which have been previously mentioned and that therefore the peritonitis itself could add little to the symptomatology. When it is realized that a meconium peritonitis (a sterile chemical foreign body reaction) can be converted within 24 hours to a bacterial peritonitis, there can be seen the possibility of overlapping in the classification. However, in reviewing the sequence of events there is hardly enough evidence available to suggest that a meconium peritonitis is a good possibility. Meconium peritonitis can result in an infant being ill at the time of birth with abdominal distention. There should be x-ray evidence of this, but this was not noted on the first x-ray film. Also when meconium peritonitis is present prenatally, scattered calcified plaques are sometimes noted throughout the abdomen. Meconium peritonitis resulting from bowel rupture after birth usually causes the infant to suddenly become ill.

Bile peritonitis is a rare condition which can be ruled out here because the abdominal distention that does occur usually appears some weeks later. These patients were slightly icteric from birth, their stools did not have normal color, and in most of the reported cases the infants were not acutely ill.

The remaining category is acute bacterial peritonitis which is the most reasonable. Sepsis with a resulting peritonitis could explain all of the events in the infant's life. However, this is unlikely since there was no history of accompanying factors such as premature rupture of the membranes, difficult labor, and infections in the mother which predispose the infant to sepsis. The absence of skin lesions, fever, icterus, and hepatomegaly also aids us in ruling out this possibility. The culturing of only coagulase negative staphylococci from the blood is another argument against sepsis. Perforation of the gastrointestinal tract resulting in the bacterial peritonitis seems likely even though the exact nature or location of the lesion is not easily discernable. This coincides with my impression of bowel rupture causing the intestinal obstruction, and I suspect that this was the result of a congenitally weak or thin intestinal wall.

PATHOLOGICAL DISCUSSION

Dr. H. M. Hillenbrand: At autopsy the infant was noted to have a distinct icteric tinge to his skin. The scalp, forehead, face, shoulders and back, and extremities were markedly hirsute. The fontanels were patent, and externally no gross deformities were noted.

The peritoneal cavity contained approximately 150 ml. of seropurulent and sanguinous fluid. There were numerous fibrin deposits throughout the fluid. The heart appeared to be somewhat enlarged to the left. No congenital abnormalites were noted. The major finding was in the intestines. In approximately the central portion of the small intestine a loop of gangrenous intestine, which was exuding fecal material and purulent debris, was seen. Within the mesentery to this gangrenous segment a large thrombosed blood vessel, surrounded

by hemorrhagic material, was palpated. The remainder of the gastrointestinal tract was covered with fibrinopurulent exudate. No signs of congenital abnormality were noted. The remainder of the gross examination was essentially within physiological limits for a newborn infant.

Microscopically the involved segment of intestine revealed a marked necrosis with ulceration of the mucosa. There were diffuse hemorrhages within the mucosa and submucosa and extensive necrosis of the intestinal wall. The serosa showed some proliferation of fibroblasts, diffuse infiltrate of acute and chronic inflammatory cells, and numerous widely dilated blood vessels containing thrombi. The thrombotic vessels for the most part were venous in nature. Sections of the mesentery revealed scattered thrombotic veins, some of which showed early organization. Throughout the mesentery there was a diffuse infiltrate of lymphocytes and polymorphonuclear leukocytes.

Microscopic examination of the remainder of the thoracic and abdominal viscera revealed for the most part extensive congestion and patchy areas of atelectasis in the lungs. Almost all of the viscera revealed a polymorphonuclear leukocytic infiltrate compatible with a circulating leukocytosis.

Mesenteric thrombosis in a newborn infant is new in my experience, and the etiology remains obscure with me. Doctor Hughes, the physician who attended the infant, and I have done some literary review without completely satisfactory results to explain the mechanisms involved.

COMMENT

Dr. John B. Hughes: Doctor Leschke did well to mention mesenteric vascular occlusion as a possibility because this is certainly a rare occurrence in the pediatric age group, especially in the newborn infants. Only 19 cases of mesenteric vascular occlusion in infancy and childhood were reported through 1960. Only 3 of these were in the newborn period. In contrast to adults where arteriosclerosis and embolism are prominent in this disease, these have little bearing in infancy and childhood. Of the 19 reported cases approximately one-third were combined arterial and venous thromboses. One was due to mesenteric arteritis, 3 were due to peritoneal bands actually compressing the vessels, and the remaining 15 cases were of unknown etiology in spite of the fact that they were all subject to pathological examination. Until now the prognosis in these patients has been poor because frequently the diagnosis was not suspected or suspected too late. In a series of 5 patients reported by Ratner and Swenson[1] all were operated upon. Four had resectable lesions and 2 survived, a survival rate of 40 per cent. Without operation the mortality rate is 100 per cent.

The only way to improve this morbid outlook is to diagnose this condition earlier so that an operation can be performed while the patient is still in good condition. The signs and symptoms of this disease are not specific so it is doubtful if the diagnosis can be made preoperatively except by some fortuitous circumstance. The diagnosis can be made by demonstrating with contrast medium a poorly functioning segment of intestine with a thickened wall that is not mechanically obstructed. It seems therefore that the only way in which more of these patients can be salvaged is to exercise a high index of suspicion for the signs of small intestinal obstruction in the newborn infants and not to delay laparotomy when these signs are present.

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A FORTUNE IS SPENT, BUT NOBODY IS RICHER

The medically needy are today a minority amid a majority of sufficiency and affluence. Accordingly, they can be identified and helped on the local level with success and thoroughness never before possible. Nevertheless, our apostles of affluence propose coast-to-coast spending schemes that offer too little to those who need it and a dividend to those who don't. This is very much like the legend of the eccentric who leaves a million dollars to be distributed in $1 bills to one million people. A fortune is spent, but nobody is richer. When the fortune spent is public money, everybody is that much poorer.—AUSTIN SMITH, M.D., to Pharmaceutical Manufacturers Association's annual eastern regional meeting.

Editor
H. F. HARDMAN, M. D., Marquette University

COMMENTS ON TREATMENT

Current Drug Therapy for Atherosclerosis

By JOSEPH J. BARBORIAK, Ph. D.
Milwaukee, Wisconsin

A FAIR AMOUNT of experimental, clinical and epidemiological evidence links the incidence and course of atherosclerosis to quantitative and qualitative changes of blood lipids. In most animal species, production of marked hyperlipidemia leads to formation of lipid-containing arterial plaques. Clinically, atherosclerosis seems to appear sooner and in more severe form in individuals with high levels of blood lipids. And, finally, without exception so far, samples of men in populations known to have a high incidence of athersoclerotic heart disease proved to have higher average serum lipid concentrations than the men of the same age in populations showing a relatively low incidence of the disease.[1] Consequently, therapeutic approaches toward control of atherosclersosis have been concentrated almost exclusively on the reduction of the elevated blood lipid levels in hope that the disease process can be reversed or prevented. As yet, there have been no adequately controlled studies which would definitely prove that a decrease of excess blood lipids would really cure or prevent atherosclerotic vascular lesions.

Many drugs have been tested in an effort to find a safe and effective antiatherosclerotic agent. According to a recent report[2] more than 60 drugs ranging from artichoke extract and gastric mucin to potassium thiocyanate and hydrocortisone were tried with various degrees of success during the last decade. The use of most of them was abandoned because of serious side effects or lack of consistent activity. At present, drug therapy for elevated blood lipid levels consists largely of two types of agents: nicotinic acid and the dextrorotatory derivatives of thyroid hormones.

Nicotinic acid when administered in large doses, 3.0 to 6.0 gm. daily, effectively lowers blood cholesterol levels; the other blood lipid classes, i.e., triglycerides and phospholipids, are reduced to a lesser extent. The mechanism of hypocholesteremic action of nicotinic acid is not clearly understood. It does not seem to be related to vitamin activity, since the hypocholesteremic response does not occur with doses of nicotinic acid that are used in nutritional disorders, and nicotinamide, which shows good vitamin activity, is without effect on serum cholesterol levels. Recent studies with liver mitochondria and slices suggest that the hypocholesteremic activity of nicotinic acid might be due to an increased oxidation and reduced synthesis of liver cholesterol.[3,4] Nicotinic acid was reported to be especially effective in reducing elevated plasma cholesterol levels in the hypothyroid state.[5]

Although it is relatively nontoxic, nicotinic acid used in large amounts produces uncomfortable side effects. Flushing due to the vasodilating action of nicotinic acid, gastric irritation and pruritus are common problems during the first days of the treatment. Occasionally, decreased glucose tolerance may occur during nicotinic acid therapy. In a diabetic patient, this may affect the insulin requirement. Activation of peptic ulcers and development of abnormal liver function tests during long term therapy also have been reported.[6,7] All of these side effects disappeared when nicotinic acid was discontinued. Attempts are being made to reduce side effects by using buffered or sustained-release forms of nicotinic acid. While some of the sustained-release preparations seem to lower the effective dose—in some cases a dose of 650

mg. daily sufficed to maintain the hypocholesteremic response[8]—they also seem to be more liable to produce abnormal liver function tests.[9] In spite of the side effects, nicotinic acid seems to be one of the safest of the presently used hypocholesteremic agents.

The dextrorotatory thyroid analogues reduce elevated plasma cholesterol levels probably by the same mechanism as the natural levorotatory compounds, i.e., by increasing the rate of cholesterol metabolism and excretion of cholic acids. However, most of them have far less effect on cellular metabolism and less calorigenic activity. D-thyroxine, for example, has about one-eighth to one-tenth of the calorigenic activity of the natural L-thyroxine.[10] The usual effective daily dose of D-thyroxine is 4 to 8 mg.: higher doses may increase the basal metabolic rate without necessarily improving the hypocholesteremic response.[11] The main side effects observed during the use of the suggested doses of D-thyroxine were heartburn, aggravation of angina,[12] and depression of thyroid activity in euthyroid patients.[13]

Recently, several other interesting preparations with blood lipid-reducing properties, such as certain estrogens, bile acid-binding resins, sulfated polysaccharides and newer inhibitors of cholesterol synthesis were reported in the literature. Definite conclusions about their value in the treatment of atherosclerosis will have to be deferred until more information about their effectiveness and possible side effects become available.

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VIRAL INFECTIONS

Zoonosis Research Laboratory

Dr. Wayne H. Thompson, State Laboratory of Hygiene, reports there were 17 cases of Psittacosis reported on the basis of clinical, epidemiological and serologic evidence in Wisconsin during 1961. Geographic distribution was as follows:

Milwaukee area	14
Beloit area	1
Boyceville area	1
Racine area	1

All but one occurred in residents of urban areas. Monthly occurrence was as follows:

January	1
February	2
March	2
April	4
May	2
June	1
September	1
November	1
December	3

Epidemiological investigation revealed, as the source of infection, a contact with one or more of the following birds: parakeets, pigeons, canaries, ducks, or chickens. No turkeys were reported as contacts.—LABORATORY NEWSLETTER, Vol. 1, No. 1, August 1962, State Laboratory of Hygiene, Madison, Wis.

School Health Program in Green County

COOPERATION is the key to the development of a good school health program. This is especially important when all the schools of a county are involved and persons concerned are widely separated. The Green County program recently has become a good example of the progress that can be made when everyone interested in school health plans together to meet children's needs.

This cooperation began two years ago in the county when school administrators became concerned about the lack of uniform county-wide recommendations for physical examinations, dental examinations, immunizations, exclusion and readmission procedures, health records, and emergency care procedures. The first step was the appointment of a subcommittee to formulate recommended school health policies which would provide guides for securing the maximum health management for each school child.

The subcommittee was composed of two school administrators, one of the public health nurses, the school health consultant for the State Board of Health, and representatives of the medical and dental societies. Several meetings were held during the school year, with the medical and dental representatives (F. C. Stiles, M. D. and R. C. Brauchle, D. D. S.) helping with health examinations and readmission procedure policies. Further cooperation was sought when each local board of education was asked to adopt the recommended policies either in toto or with modifications.

The Green County School Health Policies as approved are divided into six sections each dealing with an important aspect of school health.

1. Physical and Dental Examinations

Physical examinations in the physician's office are recommended for each school child. If at all possible, the child should be accompanied by one or both of the parents. These physical examinations should be given upon entrance to school, before fifth grade, and before ninth grade.[1] A fourth physical examination is advised during the senior year. Annual dental examinations are recommended.

The policies further state that school and health examining personnel have the responsibility for informing the parents regarding findings so that necessary care and treatment can be provided. This is particularly true in the junior and senior high schools since parents are usually not present during the examinations.

2. Control of Communicable Diseases

The policies recommend that school and health personnel function cooperatively to provide necessary immunization and vaccination at the intervals advised by the Green County Medical Society.

3. Readmission Procedures

A medical examination is recommended before readmission to school after illness of over a week's duration. The majority of the county physicians questioned on this procedure agreed. This assumes that the parents already are providing adequate medical supervision and are periodically having their family physician evaluate their child's health.

The policy goes on to say that if, in the teacher's opinion, the child still seems ill and should not be in school, under usual circumstances the school administrator should support that judgment.[2] In questionable or problem cases, administrator-teacher conferences or physician or school nurse consultation is advisable. This implies that all teachers will have a basic understanding of physical, emotional, social and mental health growth and development. This teacher will then be equipped to be a "suspectician." The policy also refers to the State Board of Health's Communicable Disease Chart as a guide for readmission following a communicable disease.

4. Health Records

The county policies stress that each school should keep up-to-date, adequate, cumulative heath records which are accessible to each teacher. Health records can be a valuable tool in health instruction. In some cases, when properly interpreted, potential outbreak of certain communicable diseases can be prevented, i.e., in the case of a low level of community immunity or a low level of reported childhood diseases, such as measles, whooping cough, and mumps. Health records indicate to the school the physician's evaluation or opinion as to whether the student is capable of participating in all school activities, or what limitations need be imposed.

5. Emergency Care and Sudden Illness Procedures

The policies recommend that these procedures be adopted: (a) For each child the school should have on file the following information: name and address of the family physician and dentist, address and telephone number of the parents' residence and

place of business, and name and address and telephone number of some other responsible person who will assume responsibility in case neither parent is available. This statement should also authorize the school to take the child directly to the physician's or dentist's office in the event of serious illness or accident when the parents cannot be reached immediately. (b) Each school building should have one or more persons holding a valid Red Cross first aid certificate. First aid supplies should be strategically located throughout the school premises. One person in each school should be responsible for seeing that first aid kits are well supplied. (c) Each building should have an area available where a child can be isolated or can rest. This area should be equipped with a cot. One person in each school should be responsible for this room's cleanliness and its supplies.

6. Teacher–Nurse Conferences

The policies recommend that teachers and nurses have at least an annual conference to discuss health problems, using the school health guidance records as a basis for discussion. The time of this conference should be convenient to both the teacher and the nurse. If preliminary screening tests, such as vision and hearing, have been completed, a portion of this conference can be devoted to referral or follow-up.

DISCUSSION

These policies, of course, do not include all the facets of school health, i.e., omitted are environment, nutrition problems and education, mental and emotional health, etc. However, they are a beginning and demonstrate how cooperative efforts can result in defining of roles and responsibilities in school health. These policies also indicate the importance of joint planning in bringing about a higher level of medical and dental supervision of the child's health.

SUMMARY

School administrators worked with representatives of the medical and dental professions to evolve standardized county-wide school health recommendations. The resultant school health program is presented.—PAUL SCHUSTER, M. P. H., School Health Consultant, Wisconsin State Board of Health, District Office, La Crosse; and FRANK C. STILES, M. D., Department of Pediatrics, The Monroe Clinic, Monroe.

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PYRIDOXINE RESPONSIVE ANEMIA

BICKERS, JOHN N., BROWN, CHARLES L. and SPRAGUE, CHARLES C. and Katherine Karst (Technical Assistant), Veterans Administration Hospital, and Tulane University School of Medicine, New Orleans, La., *Blood*, 19:304 (Mar.) 1962.

Vitamin B_6 deficiency in an adult man was first described in 1956. Since then 9 further cases have been described in the literature; this paper is a report of a further case. All cases except one have exhibited hypochromia, microcytosis, and an elevated serum iron. The anemia fails to respond to iron therapy. Age of onset is variable. In 2 cases anemia has been present since birth. All cases to date have been males. Splenomegaly and shortened red cell survival have been constant findings. Response to pyridoxine therapy is incomplete in about half the cases.

The case report of a 51-year-old Negro male is presented in detail and covers a period of more than 20 years, since he was first noted to have an asymptomatic hypochromic anemia in 1939. Six months following splenectomy in 1956, he started taking an oral hematinic agent containing vitamin B_{12}, ferrous sulfate, liver fraction II, folic acid, thiamine, riboflavin, nicotinamide, pyridoxine, and calcium pantothenate. Each component was subsequently administered individually and pyridoxine was shown to be the significant ingredient. However, each remission with pyridoxine was accompanied by numerous venous thromboses and pulmonary emboli.

The clinical picture closely simulates thalassemia; however, fetal and A_2 hemoglobin levels are normal. No other defects attributable to vitamin B_6 deficiency were noted.

It is suggested that this group of patients has an increased need for this vitamin since an inadequate dietary intake is unlikely and there is no evidence to suggest a decreased absorption rate. Other authors have suggested that the increased iron stores in some way bind pyridoxal and render it ineffective. This anemia may have a congenital basis, but the same defect may not be present in all patients.

STERILIZATION TECHNIQUES FOR THE MEDICAL OFFICE—FILM

Wyeth Laboratories, Philadelphia, has released a new 29-minute, 16-mm color, sound motion picture on "Sterilization Procedures for the Medical Office." The new film demonstrates the proper techniques for sterilizing and disinfecting medical instruments and supplies. The recent upsurge in hepatitis has focused renewed attention on sterilization methods as a means for preventing the transmission of the disease during office procedures. Loan prints of the film are available from the Wyeth Film Library, P.O. Box 8299, Philadelphia 1, Pa.

THE PRESIDENT'S PAGE . . .

Available Medical Care Is Not Utilized

THE ADVOCATES of paying for medical care through social security funds claim that great numbers of people do not have medical care. Next, they assume that these people lack medical care only because funds are lacking. This may be true for some, but the number is much smaller than Washington, D. C., is telling us, and financial troubles are not the only ones.

Every doctor who has been in practice a decade or two has been frustrated by people who not only neglect medical care but also adroitly evade and even fight off efforts by their families and doctors to give them care. Age, pain, or disappointments may have fully erased any desire to live, so they refuse to be treated. The suicidal person as well as those whose scruples forbid suicide seek to die prematurely through neglect or the use of liquor, drugs or other measures they do not consider actually suicidal. Another common form of neglect appears in the patient who wants only his blood pressure taken or his urine specimen examined but refuses thorough medical examination even when the logical reasons for doing so are explained to him.

In the past two decades, medical science with its advanced techniques and laboratory studies has made astounding strides. However, our efforts to keep patients aware of these developments have failed. We need continued and concerted education of the public to insure maximum use of our scientific advances. Even in the case of Diabetic Detection Week, which is offered free, very few people respond to the pleas for examination. Free chest x-rays are also not in favor with the general population. It seems impossible that anyone would pass by the trailer when less than five minutes' time is required. The Papanicolau test represents the best of the newer diagnostic tests for a disease—uterine cancer, yet it is appalling how little it is used or requested. We must keep our educational campaigns alive—not just for our own patients but also for the patient who calls a physician for acute illness only.

The utilization of medical and hospital care has increased rapidly and is almost as responsible for increasing costs as the requirements of our aging population. The increase in utilization is due to education and not the enactment of laws.

(continued on page 578)

DIABETES MELLITUS AND PRIMARY CARCINOMA OF THE PANCREAS

CLARK, CHARLES G. AND MITCHELL, PETER E. G.—*British Medical Journal* 2: 1259 (Nov. 11) 1961.

A case of sarcoma of the pancreas was observed in a patient who had been discovered to have diabetes 15 months before. This led the authors to review the case records of all patients with proved neoplasm of the pancreas, and of all patients with diabetes seen in the Aberdeen Royal Infirmary during the years 1955 to 1959.

Of 65 patients suffering from primary neoplasm of the pancreas in the period under review, 10 (15.4%) also had diabetes. In all but one of these cases, the symptoms of diabetes shortly preceded those due to the carcinoma or the diabetes was discovered on routine investigation after admission to the hospital. All the patients were over 60 years of age, none was categorized as an obese diabetic and in each case the diabetic state was considered mild to moderate, never severe.

During the same period, 729 patients were newly discovered to have diabetes. These were divided according to age and as to whether they were stable or unstable diabetics. (Stable diabetics were defined as being overweight, without tendency to ketosis and insulin-resistant; unstable diabetics as underweight, with a tendency to ketosis and insulin-sensitive.) No case of pancreatic neoplasm occurred in a stable diabetic. Of 52 cases of unstable diabetes, 21 occurred in patients aged 60 or over, and 10 (48%) of these had a primary neoplasm of the pancreas.

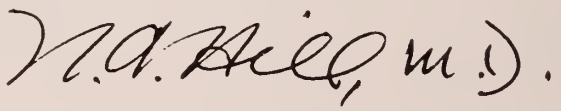
The authors conclude that neoplasm of the pancreas and diabetes are often associated and that patients who, late in life, develop diabetes of the unstable type, should be suspected of harboring a pancreatic neoplasm until proved otherwise.—*International Medical Digest*, Vol. 78, March, 1962.

THE PRESIDENT'S PAGE *(continued from page 577)*

Our nation is the only major nation in the world where the national government has so far avoided interfering in medical practice. Only public health problems are in the domain of our local and national governmental units. Our nation also enjoys the best medical care in the world and our citizens enjoy the best health of any nation. The correlation of the excellence of our national health and medical care with the freedom from governmental interference seems logical. Our progress has continued unabated because it is free; it has slowed elsewhere under government regulation.

Some of us remember the Volstead (Prohibition) Act, and the complete failure of legislation and law enforcement to accomplish the noble purposes of its advocates. Indeed, there is a curious and really amazing similarity in the halls of our Congress today with the attitudes and debates leading to the enactment of Prohibition. Have the zealots merely found another field? Education, not laws or law enforcement, has the greatest hope for the future health of our people. The centuries of enforcement of laws intended to control and punish crime is the classic example of effectiveness of governments everywhere to prevent crime. Even laws to enforce education have their failures in every community.

There is no conclusive evidence that legislation will improve medical care. There is great danger that an added tax burden will only result in another legislative failure. It would seem that the greatest contribution the government could make would be in the field of health education.



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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

K.O. for R.D.

NEXT MAY and June the National Tuberculosis Association and its affiliated groups will launch a campaign to alert people to the symptoms of chronic respiratory disease. The program will dramatize the serious threat to health that may be indicated by a persistent cough or by shortness of breath.

The purpose of the campaign will be to encourage people to seek medical advice from their own physicians about two common symptoms—cough and dyspnea—that may continue without apparent cause. According to James E. Perkins, M.D., managing director of the NTA, the program will seek to educate them to the dangers to diseases affecting or transmitted through the respiratory tract, while avoiding the creation of undue alarm.

The National Tuberculosis Association is no novice in the field of educational campaigns for health care. For years its tuberculosis campaigns emphasizing early detection to prevent serious consequences have saved untold thousands of lives. While respiratory diseases are not considered a dramatic medical problem, it is gratifying that the NTA has recognized the increasing importance of this area of health care and has undertaken a valuable effort to focus attention on symptoms that may portend disaster, and that could be avoided if the disease were detected at an early stage.

When the campaign is launched, local associations will seek the assistance of local medical societies. It is to be hoped that the cooperation given by the medical profession will be generous and cordial. By helping the local affiliates of the NTA in their 1963 respiratory disease campaign, you will be making a major contribution to the health care of your patients.

Seat Belts Are Comfortable

There is a great deal being said these days about seat belts for cars. Safety officials, insurance companies and law enforcement officers have been urging the motorist to install and use these seat belts.

Practically all of these admonitions stress the safety factor. It is pointed out that your chances of being killed are one-third less. That your chances of being injured are reduced when in an accident.

Undoubtedly these points are the major factors to consider when installing seat belts. But there is a factor, generally overlooked, that might be a better selling point.

Seat belts are comfortable. Not only do they add to the safety of the car, but they add to the comfort.

This is particularly true on long trips. Seat belts promote better posture which results in less fatigue.

Drivers who have made long trips and have worn seat belts agree with this.

Most seat belts purchased are being bought with safety in mind. But the personal comfort factor is an added dividend.

And it may save your life.—Editorial reprinted from the *Green Bay Press Gazette*, Sept. 25, 1962.

Doctor's Viewpoint

On Aug. 13 a Senior Citizen wrote favorably about medicare. This identical letter ran in the Capital Times on Aug. 11. A foot note by the Gazette editor clarified one or two points and at least two other people since have written letters deploring the expansion of medical care under the Social Security Act.

Our Senior Citizen stated that the American Medical Association had spent $7 million lobbying for the defeat of the King–Anderson bill. This large sum seemed incorrect in the face of it, and it has taken some time to learn the truth. My information comes from the figures filed with the Clerk of the House of Representatives and printed in the Congressional Record. The record shows that the AMA spent $163,404 in 1961 while the labor unions spent $1,010,365.51. The parent AFL–CIO organization led the spending of its affiliates with a reported total of $133,919.00. The AMA lobby, aside from medicare expenses, also works to support much other constructive legislation such as air pollution controls, federal research grants, hospital care for veterans with service-connected disabilities, civil defense, measure for federal grants for medical school construction and other bills of public interest.

What we need to know is how much of our tax money has been spent by the Department of Health, Education and Welfare on lobbying for the King–Anderson and other legislation. Leonard W. Larson, M. D., past president of the AMA, said, "I also doubt that fair-minded citizens would approve of the administration showing favoritism in this regard to one organization over others simply because it is lobbying for a bill sponsored by the administration."

I hope I have made it clear that it is organized labor who is spending eight times more than the AMA. At least in 1961 they were the nation's champion lobby spender.

It is unfortunate that President Kennedy is making such a political issue of the medical care for the aged in the forthcoming November elections. He seems to be hot for any kind of a medical care legislation. When Sen. Hubert H. Humphrey came out of a White House strategy session, he told waiting newsmen, "I want to tell you the President has the bit in his teeth about medicare. He was kindly and soft spoken on the steel price case compared with the determination to get action for his medicare program."

With this challenge the American people will have to make a decision whether our profession is to be socialized or not within a year or so. And many of the doctors are going to have to become politicians instead of practicing medicine. This means that little by little we will eventually have a system such as Great Britain has had to endure for 17 years. This means that some day our medical profession may have an incident not unlike that recently experienced in Saskatchewan.

I sincerely hope that the Democratic party strategists will prevail on the administration to change its mind and not make the practice of medicine a political football.—M. D. Davis, M. D., Milton. (Reprinted from the *Janesville Gazette*, Sept. 1, 1962)

The Headlong Rush Toward Disaster

If this country is to survive as anything resembling the democracy of stalwart individuals standing upon their feet through the free enterprise system that it was intended to be by the men who died at Lexington, Concord and Valley Forge almost two hundred years ago, the headlong rush toward the ultimate disaster of a welfare state must be discouraged. Traditionally, the medical profession has always been in the forefront of this battle; even now we are under heavy fire to bring us, too, under the domination of the government. If we fail to stand firm, the cause is lost beyond redemption.—WHAT PRICE WELFARE?: Frank G. Slaughter, M.D., *Journal of Florida Medical Association*, December, 1961.

Charitable, Educational and Scientific FOUNDATION

OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE CHARACTER of the medical profession shapes not only its own destiny but has profound influence on the health and well-being of all the people of Wisconsin. This character finds its root in the centuries old American belief that individual freedom and well-being hinge on people helping themselves and one another. Nowhere is this credo held in greater respect than among the members of the medical profession. For 120 years the State Medical Society of Wisconsin has reflected this spirit in its activities and services to the public and to member physicians. To do otherwise would violate the sacred vows of the Hippocratic Oath as well as the public trust.

For many years prior to 1950 the leadership of the State Medical Society was aware that many of its members, as well as friends of medicine, were interested in making grants or contributions to projects affecting medicine and public health. Such grants, if made to the Society, would not be deductible by the givers for income tax purposes, a fact which very likely had been a deterrent to such gifts.

The first tangible step in the development of the Charitable, Educational and Scientific Foundation of the State Medical Society occurred in 1951. At that time several physicians among the officers of the Society were instrumental in causing the establishment of a trust which was known as the State Medical Society Student Loan Fund. It was created in response to an obvious and pressing need to assist worthy and needy medical students who encountered serious financial problems in the pursuit of their medical careers.

However, it became increasingly evident that it would be desirable to establish a single organization which could receive contributions for broader purposes related to charity, education, and scientific research. An organization which solicits such contributions and administers them in accordance with the intention of the givers or in the best judgment of the management of such a body is commonly referred to as a "foundation." When it is organized in accordance with state and federal income tax laws, the organization is exempt from such taxation. Gifts or grants made to such an organization are deductible by the givers, whether they be individuals or corporations. Dual exemption thus makes a foundation attractive in these days of high taxes.

It was felt that the potentialities of a charitable, educational and scientific foundation would be almost unlimited. Many unsolved scientific, educational and economic questions have grown out of or are related to the practice of medicine today. They are the subject of much speculation and much writing for which there often exists no adequate factual basis. Many statements are made in government circles which represent either inadequate studies or confused conclusions. Medicine has a direct obligation to the people, as well as to itself, to determine or review facts underlying such problems and, where necessary, to state, restate, or correct conclusions. The very freedom of medical science may be dependent upon the manner in which these problems are studied and presented to the public. All too often the public accepts what appears to be an answer, but what, in fact, is not an answer. The medical profession should study these problems and propose solutions, as a matter of qualification, public interest, and legitimate self interest.

Such studies cost considerable amounts of money. The Society had almost more than it could bear in the way of expense for these related projects. It was apparent that if additional funds could be channeled to effective use in such studies, the studies could be completed more rapidly and with greater benefit to all concerned.

At the same time it was apparent that enlargement of the fund for loans to medical students was urgent. Mechanisms were also necessary for making grants to disabled physicians or widows of physicians who had met with misfortune. The lack of such assistance might result in these individuals becoming public charges in part or in whole.

The medical profession or certain of its members might be interested in having special studies made in fields in which no other grants were available. Physicians have frequently commented that a few of the fields and problems of medicine have relatively generous funds accessible for study while others have nothing at all. It was felt that the Foundation would be able to correct this inequality in areas where physicians and scientific organizations in Wisconsin showed interest which was felt to be worthwhile to the advancement of science and public health.

With this background and this philosophy in mind, the Council, in May 1954, authorized the study in preliminary organization of a foundation. Experience has demonstrated that the overwhelming majority of similar organizations take that form, because their continuation is not so directly dependent upon individuals as in the case of a trust or unincorporated association. Further, there is a tendency on the part of givers to prefer that the

object of their gifts be a corporation; and they attach an increased stability and likelihood of survival to an incorporated foundation.

Therefore, the Council recommended and the House of Delegates in October 1954 accepted a proposal for the incorporation of a Charitable, Educational and Scientific Foundation as a nonstock corporation.

POLICY AND ADMINISTRATION

The Charitable, Educational and Scientific Foundation was created in 1955 by the State Medical Society of Wisconsin as a nonstock corporation under Wisconsin statutes. The Foundation is under the direction of a Board of Trustees composed of an elected member from each component county medical society and the councilors and officers of the State Medical Society of Wisconsin plus up to ten nonmedical trustees.

The councilors and officers of the State Medical Society constitute the Executive Committee of the Board of Trustees of the Foundation. An annual meeting of the Board of Trustees is held at the time of the Annual Meeting of the State Medical Society and at that time officers are elected. The officers consist of a president, vice-president, treasurer and secretary.

At the present time there are 5 officers, 54 representatives of component county medical societies, 5 nonmedical trustees, and 27 officers and councilors of the State Medical Society—all of whom compose the Board of Trustees of the CES Foundation. The total number of trustees therefore is 91, although 5 of these are serving dual capacities.

Terms of the county society representative are for three years and are so staggered that approximately one-third of the members are elected each year, thereby helping to insure stability.

Inasmuch as the Secretary of the CES Foundation is also the Secretary of the State Medical Society, the administrative staff of the Foundation coincides with that of the Society.

OPPORTUNITIES FOR GIVING

Financial support of the Foundation is achieved in many ways. Voluntary contributions are solicited of physicians each year in an amount determined by the House of Delegates of the State Medical Society. All physicians in active practice are solicited. From July 1, 1955, when the CES Foundation was created, through June 30, 1962—a period of seven years—individual member physicians of the State Medical Society have contributed $118,943.45 and component county medical societies, $11,387.00, for a total of $130,330.45 to the Foundation. There have been numerous other contributions and grants.

Physicians, nonmedical persons, business, industry, and other foundations have found the CES Foundation an avenue of common interest and effort. All contributions to the Foundation are deductible for income tax purposes.

Gifts can take a number of forms, any of which are welcome to the Foundation. One is cash; a second is life insurance; a third is securities; a fourth is land, with or without improvements; and still another is artifacts. The latter would typically include instruments, books or equipment associated with a particular period of medical practice. Also in this category would be correspondence, diaries, account books, class or community pictures or the like.

Gifts to the Foundation may be of two types. They may be unrestricted, in which event the Foundation is free to use them for any of the purposes for which it was established. The second is the restricted type, under which conditions of some sort are attached at the time the gift is made. An obvious example of the latter is a gift to the Student Loan Fund. Another would be a gift to the Museum of Medical Progress at Prairie du Chien.

There are some disadvantages in restrictive gifts. One is the possibility that the object of the gift may disappear, or that it may receive ample funds from other sources at some subsequent date. A second is that a restricted gift imposes additional administrative burdens upon the Foundation's staff. As a general proposition, it is likely that a Board of Trustees of some 90 members, including both physician and nonmedical members, is in an excellent position to develop and to budget for projects worthy of the Foundation and consistent with its purposes.

The Foundation has developed a memorial card which is sent to the relative or friends of deceased persons upon the request of the donor.

It should be pointed out that individual effort seldom has the opportunity to become significantly effective or to be given proper credit for a contribution to society. Now, through the Charitable, Educational and Scientific Foundation of the State Medical Society, physicians and others have an unprecedented opportunity to give of their substance to deserving causes of medical and public health interest with the assurance that their contribution will be productively utilized and that posterity will be cognizant of their acts.

CONTINUING PROJECTS

There are many continuing projects which are administered by the Foundation. Only a brief mention of each can be made in this report. Complete details of each project will appear in subsequent issues of the *Journal.*

Medical Student Loan Fund: Since 1951, a total of $101,045.00 has been loaned to 108 medical students. Currently the Foundation provides assistance to 76 students with at least 20 applications pending from deserving students for whom no funds are available.

Museum of Medical Progress: One of the great educational and cultural institutions of the nation has been in the making at Prairie du Chien since 1917. The Museum, located on the site of historic Fort Crawford, establishes a new concept in museums.

It is not the intent that this be solely a museum of Wisconsin medical history, but rather an educational center showing the progress of medicine and military medicine in the Midwest, the Nation and the World. A complex of several buildings is nearing completion. The latest addition is the Stovall Hall of Health, completed in 1962, which is devoted to exhibits which portray the changing pattern of scientific advancement in medicine and health care.

Scientific Medicine: Medicine is an ever-changing and increasingly complex science. The physician is therefore faced with a never ending challenge to maintain his education, his art, and his skills at a level that keeps pace with scientific progress.

The importance of the Foundation in supporting postgraduate education and scientific research is emphasized by the fact that during the past year, 1961–1962, a total of 2,508 persons attended the postgraduate programs sponsored by the Foundation. These activities included a Speakers Service to county medical societies, circuit teaching programs, and special conferences on problems of the newborn, prematurity institutes, maternal mortality institute, a conference on mental retardation, and conferences on medical aspects of sports.

Charitable: The devotion of the physician to alleviation of suffering and service to mankind is sometimes so steadfast that he may not see the opportunity among those of his own colleagues to whom misfortune has come. The number of physicians and their families touched by severe disability, financial insecurity, or similar personal disaster, is not great but it is, nonetheless, impressive. There is an obligation on the part of professional persons to look out for colleagues who suffer adversity. The Foundation offers unusual opportunity to help physicians and their families who might be victims of misfortune.

Microscope Loon Progrom: Through contributions the Foundation has acquired several microscopes which are on loan to medical students.

Medicol Stamps: The Foundation's stamp collection, now numbering more than 3,000 issues from most of the nations of the world as well as the United Nations, is being used to illustrate talks on health careers, the progress of public health in medicine, and in displays of art in universities, art galleries, and other public showings.

Historicol Morkers: An extensive program is underway to locate and identify persons, places and events and circumstances which have significance in the public health and medicine in Wisconsin. As these are located and appropriate financial assistance is found, markers will be erected to commemorate the situation. The first of these was erected in Milwaukee in 1960 honoring Dr. Nicholas Senn, noted pioneer, physician and surgeon, from Wisconsin.

Hobbies for Health: To emphasize the importance of physicians and others in having outside interests for better health, the Foundation encourages development of hobbies. Such hobbies may be of material value, by way of exhibit or display, in stressing this health aspect. The Arveson bell collection and a collection of occupational shaving mugs, recently donated to the Foundation by a Milwaukee physician, gave the project material support.

Collection of Artifacts: The Foundation receives, almost daily, from physicians and others items which have historical significance in medicine as well as other nonmedical fields. Many of these are on display at the Museum of Medical Progress, others are on display in the State Medical Society headquarters in Madison, and still others are awaiting display when space is available and when a particular occasion or subject warrants attention.

Reseorch Studies: Cost of medical care, insurance needs of the aging population, and hearing losses are all under study through special grants. A study of the Menominee county health needs is also being conducted.

Memoriol Lectures: A method for commemorating a physician, a person, an event, circumstance or purpose was established by the Foundation in the form of memorial lectures. Thus far, three such lectureships have been approved: Dr. William Beaumont, Dr. Wilson Cunningham and Conrad Elvehjem. The Beaumont lecture is presented each year at the Annual Meeting of the State Medical Society. The Cunningham and Elvehjem lectures may be held at any time when the occasion presents itself.

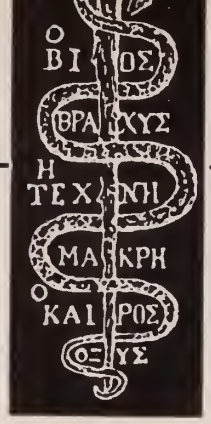
Memoriol Fund: The State Medical Society contributes $15 to the Foundation in memory of physician members. Individual physicians and others also contribute money in memory of individuals, not necessarily physicians.

PENDING PROJECTS

The long-range planning of the Board of Trustees of the Foundation includes numerous projects still on the drawing boards or in the discussion stage. To name a few: presidential garden, Gavin memorial circle, Council room mosaic mural depicting the history of medicine, flowers in medicine, women and medicine exhibit, healthmobile, memorial trees, seals for each component county medical society, a conference on industrial health, conference on home care of the aging, a pavilion and other exhibit buildings at the Museum of Medical Progress at Prairie du Chien.

VOLUNTARY SUPPORT

The Foundation offers a permanent and reliable mechanism for administering and accepting voluntary contributions to further the charitable, educational and scientific programs which are a vital link in the continuation of medical progress in Wisconsin. The voluntary support, financially and physically, by Wisconsin physicians is an integral part of the success of the Foundation.



Charitable, Educational and Scientific Foundation

of the State Medical Society of Wisconsin

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THE MEDICAL FORUM

Plans Proceed with Sabin Oral Polio Vaccine

Nine Wisconsin counties are proceeding with community-wide Sabin oral polio immunization programs, while several others have postponed their plans and are waiting for more detailed reports on the use of Sabin type III. Although the city of Milwaukee is dispensing Sabin oral vaccine in its six-month campaign to eradicate polio, other areas in the county have postponed their programs.

RACINE

The Racine County Medical Society set the pace throughout the state both in educating the public on the value of the Sabin oral polio vaccine and in administering it.

More than 3,000 workers devoted 75,000 man hours of volunteer labor over a period of six months to organize Sabin Oral Sunday in Racine county October 21. Their labor paid off when nearly 130,000 persons turned out at 30 clinics located throughout the county for their doses of Sabin oral vaccine type I.

"This laudable effort to make Racine county safe against polio has been dramatized better than anything I have ever seen in about four decades of newspaper experience," **Tex Reynolds**, veteran columnist for the *Racine Journal–Times*, wrote.

Makeup clinics were scheduled for the following week for those who did not receive the vaccine the previous Sunday, and special arrangements were made to accommodate shutins, including 56 prisoners in the county jail.

Of the total who were immunized, 126,000 listed residence in Racine county (90 per cent of the county population). The average donation to defray costs was 20 cents per person. Sponsoring groups had sought a 25-cent per person contribution from those able to pay.

Type II vaccine will be given in Racine county on December 2. No plans have been announced for administering type III.

Cosponsors with the Racine County Medical Society include the Racine County Pharmacists Association, Racine District Nurses Association, Racine County Board Committee on Hospitals and Health, and the Racine County chapter of the National Foundation. Volunteer workers were supplied by the Junior Chamber of Commerce, Jaycettes, League of Women Voters, Medical Assistants Association, Parent Teachers Association, Racine Citizens Radio Band Club, Amateur Radio Emergency Radio Corps, American Legion, Boy Scouts, and hundreds of individual volunteers.

STATE BOARD OF HEALTH RECOMMENDATIONS

The Poliomyelitis Advisory Committee to the State Board of Health met September 18, 1962, and made the following recommendations:

On the basis of present information the committee recommends either of two methods for immunizing against poliomyelitis:

1. Continue with the immunizations using the Salk vaccine with the understanding that periodic booster doses will be required.
2. Use type I and II oral vaccine without restriction and type III Sabin oral vaccine only for those persons who have had at least two doses of Salk vaccine, the last of which shall have been given within one year prior to the feeding of type III.

It seems to be advantageous that type I oral vaccine shall be used as a first dose followed by type II after six weeks, and the type III to be administered after an interval of at least eight weeks following the type II feeding.

PIERCE–ST. CROIX

On October 26 and 27 the Pierce–St. Croix County Medical Society conducted its first phase of a county-wide program to administer oral polio vaccine to every person in the two counties. A month of extensive newspaper coverage alerted the citizens to the program. Clinics for type II polio vaccine will be December 7 and 8. Type III will be administered in the spring of 1963.

MILWAUKEE

In Milwaukee county, the city of Milwaukee is combining Salk vaccine with the use of Sabin oral vaccines in its polio immunization program which it hopes will reach 600,000 people. Whitefish Bay, Shorewood, Cudahy, and South Milwaukee have postponed any public administration of the oral vaccine.

SHEBOYGAN

Sixty thousand doses of Sabin vaccine type I were offered to the Sheboygan county populace on October 21. Five dispensaries were set up in Sheboygan and one in Plymouth. Working with the Sheboygan County Medical Society in conducting the mass polio immunization clinics were the Jaycees, Sheboygan Service Club, Ozaukee–Sheboygan County Medical Assistants Society, Sheboygan Women's Club, Y's Men's Club, Jaycettes, North and South High Junior Red Cross groups, and nurses employed by the Sheboygan Health Department.

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90% Participation Achieved in Racine County Medical Society's "Sabin Oral Sundays"

EDITOR'S NOTE: *The following is a preliminary report by Bruce V. Winter, M.D., Union Grove, coordinator of the Sabin immunization program for Racine county, on the type I "Sabin Oral Sundays" held in Racine county in October.*

On Sunday, October 21, over 124,000 Racine county residents received type I Sabin oral polio vaccine, and, in so doing, justified the Racine County Medical Society's belief that the current controversy over type III Sabin vaccine did not mean automatic public rejection of type I and type II programs. On the next Sunday, October 28, an additional 5,000 residents received type I vaccine, bringing the total number of voluntary participants to approximately 130,000. Of this, 126,000 were men, women, and children listed as county residents by the 1960 census—over 90 per cent of the total county population.

STATUS OF TYPE III

The status of Sabin type III attenuated live-virus oral polio vaccine is still controversial at the time of this report. For a detailed analysis of the problem, please consult the recent technical report by U. S. Surgeon General Luther L. Terry, M.D., entitled "The Association of Cases of Poliomyelitis with the Use of Type Three Oral Poliomyelitis Vaccines," published by the U. S. Department of Health, Education and Welfare on September 20 of this year.

Racine Journal–Times Photo

MORE THAN 3,000 VOLUNTEER WORKERS devoted 75,000 man hours of labor over a preparation period of six months.

The City of Milwaukee Health Department, which started its Sabin type I program October 29, has announced plans to administer Salk vaccine to everyone after completion of their type II Sabin vaccine program this year, but before beginning their Sabin type III program next spring. For the time being, the Racine County Medical Society has made no definite plans beyond December 2, 1962, when we will administer type II vaccine to, we trust, better than 90 per cent of our county's residents. Plans for our type III program will be delayed until some uniformity in official recommendations has been reached.

While we are unhappy that completion of Racine county's oral polio vaccine program may have to be delayed, there are certain advantages to be gained by a delay after type II: It will give our population a chance to recover from the deluge of news and advertising descending on them incident to the program, and allow a "fresh approach" when we do announce plans for the final immunization. Also, by breaking up the program in this manner, our many volunteers will have a chance to recapture some of their original enthusiasm and make the last Sabin Oral Sunday less of a chore and more of an enjoyment for everyone.

Breakdown as to Age and County for 126,661 Individuals Tabulated to Date

OUT-OF-COUNTY

County	*No. Tabulated*
Kenosha	1,631
Walworth	1,163
Other*	1,290

* This includes residents of 12 other Wisconsin counties, Texas, Seattle, Los Angeles, Chicago, and several other Illinois communities.

RACINE COUNTY

Years	*No. Tabulated*
0–1	5,087
2–5	13,992
6–10	16,309
11–15	13,516
16–20*	7,750
21–40	29,309
Over 40	31,347
No age given	5,267

* The relatively low figure for this age group reflects adolescents who were refused vaccine because of no parental consent and also the substantial number of residents in this age group away at school or in military service.

Racine Journal–Times Photo

WIDESPREAD PHYSICIAN PROMOTION AND PARTICIPATION established the public's faith in the program.

Even if administration of type III vaccine is not accomplished in Racine county by next summer, a genuine public service will have been accomplished by the type I and II programs: Epidemics of type I polio and, after December 2, epidemics of type II polio will probably be an epidemiological impossibility in Racine county for at least a number of years since epidemics of poliomyelitis require "silent" transmission of wild-strain virus through the community. This transmission will be effectively blocked for a number of years, at least, by immunization with live-virus oral polio vaccine. Theoretical calculations indicate that a chain of transmission is extremely unlikely to become established in a community when more than 70 per cent of the population is unable to pick up and pass on the virus. This criterion is more than satisfied by

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Racine County

(continued from page 586)

the county's over 90 per cent participation in the type I program.

PLANS FOR OTHER COUNTIES

Whether other Wisconsin medical societies should plan Sabin Oral Sundays this year is a matter to be carefully reconsidered by each county medical society at this time. We feel our experience certainly indicates that Wisconsin residents, when offered the program as in Racine county, will overwhelmingly participate in medical society sponsored oral polio vaccine programs. We have also demonstrated that a successful program is possible without outside financial backing and with 100 per cent volunteer labor.

Racine Journal–Times Photo

5,000 TOTS LESS THAN TWO YEARS OLD were among the 130,000 persons who turned out for Sabin orol vaccine type I.

GOOD PRESS RELATIONS ESSENTIAL

As soon as even tentative plans are authorized by a society, newspaper and radio stories about the program should be released. A good working relationship with the press and radio is essential to success. Mass vaccination programs of this magnitude are sources of literally hundreds of newsworthy facts, questions, and interesting details. If possible, some member of the society should be appointed press officer to plan a slowly accelerating schedule of news releases as the program progresses.

KEEP MESSAGE SIMPLE

One of the most important factors in our program's success was the simplicity of "the message" repeatedly delivered to the public by every conceivable means and media. Since programs elsewhere had been aimed at certain "target groups" of under-immunized individuals and had failed to reach these groups, we simply advised *everyone,* from six weeks of age and up, regardless of previous immunizations, medical conditions, etc., to participate. As a result, even several 90-year-old persons are found among our tabulated vaccinees, and the decision of these older members of a family to "Join the Fight to Lick Polio Forever" undoubtedly favorably influenced many younger family members to do the same. Our slogan, "Come together as a family," also served the same purpose.

PHYSICIANS MUST SUPPORT PROGRAM

The great majority of the individual practicing physicians in the community must believe in and *actively* promote Sabin Oral Sundays throughout the campaign. Without substantial and widespread physician promotion, the public will not pay much attention to other promotional materials, and a failure in turnout for vaccine will result.

Also, early, active support of a county's pharmacists and registered nurses is important. In Racine, physicians, pharmacists, nurses, and their families took the vaccine one week before the public. Frequent references were made in the press and on the radio during the last week to the fact that the public would be given the "same, safe polio protection already taken by physicians, pharmacists, nurses, and their families" the previous Sunday.

A Physicians Speaking Bureau was formed, and over 75 separate 10 to 15-minute appearances by different physicians were made before union meetings, church groups, PTA, PTO and other similar organizations during the four weeks prior to October 21. Brief taped personal endorsements of the program were made by locally prominent physicians, and these messages were broadcast over two local radio stations with daily increasing frequency during the last week of the campaign.

EXTRA EFFORT PAYS OFF

No ethically sound promotional idea should be left unexplored, no matter how minor, if implementation of the idea will not detract from work on more promising ideas. In Racine, individual inserts were prepared for each cooperating physician's October statements which stated that he and his family planned to take the vaccine, and that he urged all of his patients and their families to do the same. Each insert was "signed" with the printed name of that individual physician and, in retrospect, these little statements were extremely important in the overall results by reestablishing public confidence in the vaccine, badly shaken when the news of Canada's postponement of all Sabin vaccine programs was announced.

QUICK SERVICE IS IMPORTANT

Careful, early planning of clinic site facilities, furnishings, and traffic control procedures resulted

(continued on page 588)

as sure as time itself . . .

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Racine Journal–Times Photo

PREVIOUS ON-SITE TESTING of clinic traffic flow floor plans resulted in almost 3,000 individuals being checked for proper registration and given vaccine in a single one-hour period on Sabin Oral Sunday in Racine County.

Racine County

(continued from page 587)

in quick, convenient service for the public on vaccination day and will make a good turnout in the future all the more likely as a result. At 1 of the 30 conveniently located community clinics, almost 3,000 individuals were checked for proper registration and given vaccine in a single one-hour period. This was possible only because of repeated on-site testing of various clinic traffic flow floor plans prior to October 21 so that a uniform, simple pretested basic plan and instructions could be used in each of the 30 clinics.

Public support and respect for the medical profession in Racine county have received an invaluable boost as a result of the Sabin Oral Sundays program. While not reason enough in itself to sponsor such a program, this dividend in good medical public relations more than compensated for the tremendous investment in man hours and effort required to run such a program successfully. The Racine County Medical Society is justifiably proud of its results.

FITNESS CONFERENCES POSTPONED

The series of Physical Fitness Conferences announced in the October issue of the *Medical Forum* have been postponed until early in 1963. The conferences will be held at various locations in the state to introduce school personnel, parents, and physicians to the second phase of the President's Youth Fitness Program.

Postponement of the conferences was made necessary by delay in the publication of the booklet outlining the second phase of the program.

The Racine County Medical Society will be happy to consult with medical societies planning oral polio vaccine programs, and any inquiries directed to Sabin Oral Sundays, P. O. Box 282, Racine, Wisconsin, will be answered as received.

Sabin Oral Polio Vaccine Plans Proceed

(continued from page 585)

Type II oral vaccine will be offered in Sheboygan county on Sunday, December 2.

OTHER COUNTIES

Plans for mass immunization with the oral vaccine also have gone ahead in Door, Grant, Langlade, Polk, and Winnebago counties. Door county clinics were scheduled for October, December, and January. Grant county will begin its program right after the first of the year.

In Langlade county, type I was given in clinics held October 5 and type II was given on November 9. Polk county will begin its program November 28–29, with type II scheduled for six weeks later and type III scheduled for next March. Only 58 per cent of the county took type I oral vaccine offered in Winnebago county at 38 clinics on September 30. Follow-up clinics were held, and type II was given on November 4 and 11.

It is on the recommendation of the State Board of Health that the foregoing counties have proceeded with their mass immunization programs. All of them feel that by the time type III is due to be administered, developments concerning its use will have been clarified.

Many counties, however, which had begun plans for county-wide oral polio vaccine clinics, have adopted a "wait and see" policy and have postponed their programs. Among them are: Barron, Chippewa, Clark, Crawford, Dane, Douglas, Dunn, Eau Claire, Green, Kenosha, La Crosse, Lafayette, Marathon, Marinette–Florence, Portage, Rock, Trempealeau–Buffalo, Walworth, Washington, and Waukesha. Waiting for further recommendations from the State Board of Health before they make any plans are Jefferson, Oconto, Price, Rusk, and Wood counties.

MEDICARE PAYMENTS IN WISCONSIN

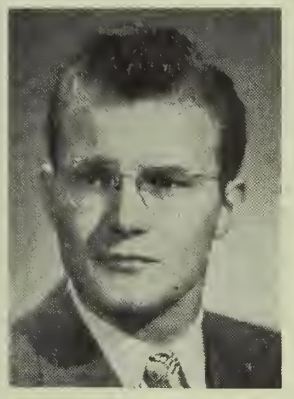
Medicare payments in Wisconsin amounted to $57,854 paid to 809 claimants during September. From January through September, 1962, 5,951 claims have been paid amounting to $437,586.

Mental Health Program Has Personnel Problem

Supply, utilization, and training of personnel for mental health programs is the major problem in meeting Wisconsin's needs in the mental health field.

This was the conclusion of the state's delegation to the American Medical Association's National Congress on Mental Illness and Health, held in Chicago October 4–6.

Over 30 persons attended, including 10 physicians. Chairman of the group was Dr. Keith Keane, Appleton, chairman of the State Medical Society's Division on Nervous and Mental Diseases of the Commission on State Departments.



KEITH KEANE, M. D.

The delegation's report also emphasized the importance of legislation aimed at increasing the role of county hospitals in the state mental health picture, and the progress desired in coordination of planning and responsibility of statewide and local programs.

PERSONNEL

Anticipating a major change in the roles played by professionals because of the continuing inadequate supply of personnel in the foreseeable future, the report recommended:

1. Encouragement of the participation and support of all physicians, regardless of type of practice, in mental health programs at both the state and local levels of responsibility.
2. Better utilization of personnel through delegation of nonspecialized responsibility to existing agencies and services.
3. Continual upgrading of proficiency of available manpower.
4. Continual strengthening of a physician recruitment program.

The delegation agreed that the state government not only must assume an aggressive leadership of the many community programs, both public and private, which are developing, but also must more and more assume obligations to these local programs of:

1. Standard setting.
2. Substantial financial participation.
3. Assuring that services are distributed equitably to all parts of the state regardless of economic or geographic problems.

Hospitalization is considered only one aspect of a continuum of services which must include primary prevention as an integral part of community services, the report stated.

Existing services—medical, public health nurses, welfare, community mental health clinics, and visiting nurses—would all serve their appropriate functions in providing services to the mentally ill and mentally retarded persons based on their needs regardless of whether they relate to institutional care.

FOCUS ON COUNTY HOSPITALS

The report pointed out that Wisconsin's system of county hospitals can form the nucleus of community mental health centers. These 36 hospitals which range in size from 150 to 400 patients are in tune with the desires around the nation and should be permitted to assume aggressive community leadership roles in the state mental health picture with substantial financial and technical assistance from the state.

The report also recommended development of maximum educational opportunities for emotionally disturbed children.

Purpose of the congress was to implement the broad, new mental health program developed by the American Medical Association.

MEDICARE POLICY ON EXPIRED I.D. CARDS

Physicians throughout Wisconsin are again being asked for cooperation and patience in dealing with Medicare patients who, because of extension of the sponsor's period of active duty, are not able to present a valid identification card when requesting care.

Retention of many servicemen beyond their normal date of discharge has been ordered. Some of their dependents can be expected to require civilian medical service before corrected identification cards can be provided. You may encounter the problem of service being requested after the expiration date shown on the card.

For handling such situations, please read the letter of the U. S. Surgeon General, printed in full on page 11 of this issue.

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Inquiries Invited

AN ELECTRONIC MAP of the United States 12 feet tall and 20 feet long is displayed at the Museum at Prairie du Chien. A 3½-minute tape recording synchronized with several hundred lights operated on a photo-electric cell gives details on education and distribution of Wisconsin physicians. Dr. Thomas *Heighway*, Middleton, constructed the exhibit for the Dane County Medical Society Health Fair held in Madison in May. Gordon *Peckham*, curator at the museum, is shown explaining the huge map to interested spectators (including Dr. W. D. *Stovall*, Madison) at the recent dedication of the Stovall Hall of Health at Prairie du Chien.

County Societies Invited to Join in AAPS Essay Contest

County medical societies and auxiliaries are invited to sponsor local competition in the 1963 essay contest of the Association of American Physicians and Surgeons.

The contest is for high school students. Prizes totaling $2,675 are being offered on the national level and county societies may offer additional prizes for local competition if they desire.

Students have two choices of topic: "The Advantages of Private Medical Care" and "The Advantages of the American Free Enterprise System Over Communism."

High school students in the 10th, 11th, and 12th grades from all public, parochial and private schools in the United States are eligible to enter, with the exception of the sons and daughters of physicians. Essays shall be a minimum of 1,000 words and a maximum of 1,500.

The contest begins Jan. 1, 1963, and essays must be submitted on or before Mar. 1, 1963, to either the local sponsor or AAPS in the event there is no locally sponsored contest. If there is a locally sponsored contest, winners must be submitted to AAPS on or before April 1 to compete for national awards.

Packaged libraries are available from AAPS for placement in school libraries to be used for research by participating students.

Further information regarding the AAPS Contest may be obtained from: James Baumgartner, M.D., Chairman, Wisconsin Chapter, AAPS Essay Contest Committee, 239 Fifth Avenue, West Bend, Wis.

Medical Centers Dedicated

Two medical clinics built under the American Medical Association–Sears–Roebuck Foundation's Medical Assistance Program were dedicated in Wisconsin in the past month.

Dr. W. D. Stovall, Madison, was the principal speaker at the dedication of the new Reedsville Medical Center in Manitowoc county on November 11.

Dr. Robert Larimer of Sioux City, Iowa, gave the dedicatory address at the opening of the Loyal medical center on October 28.

Kenosha Physicians Help Reduce County Care Costs for Aged

Cooperation of the Kenosha County Medical Society with the county welfare department in transferring aged persons more quickly from hospitals to convalescent facilities at the county-operated Brookside home, along with careful screening of medical charges, has helped reduce welfare expenses, Paul Hickey, Kenosha county welfare director, has stated.

A "holding and slight reduction" in various aid categories explained a decreased 1963 budget figure for the Kenosha county welfare department.

Since June, 1960, an agreement between the Kenosha County Medical Society and the trustees of Kenosha County's Willowbrook and Brookside sanitariums has provided for a prepayment medical care program known as the Kenosha Physicians Service.

Under the plan, money budgeted in the county welfare account for medical care is paid to the County Medical Society. Patients at the two sanitariums, 90 per cent of whom are on public assistance, are free to call their own physicians when needed and they in turn bill the Society for their services. Participating agreements have been signed by 100 per cent of the active practicing physicians of the Kenosha County Medical Society.

If patients' bills amount to more than the amount received from the county each month, physicians are paid pro rata amounts of their bills and absorb the loss. If not all the money in a given month is used, the excess goes into a specially created nonprofit Kenosha Physicians Service Foundation to support charitable, educational, and scientific endeavors, chiefly related to the two county hospitals.

STANDARD INSURANCE REPORTING

Standard insurance reporting forms to be used for reporting to all insurance companies have been printed by the Dane County Medical Society.

The public relations committee, by direction of the Society's board of trustees, devised the new standard insurance reporting forms to facilitate filling out reports.

CES Foundation Speakers Provide 52 Programs

Scientific speakers for 52 programs, reaching a total of 1,450 physicians, were provided by the Speakers Service of the Charitable, Educational and Scientific Foundation of the State Medical Society during the past year.

The Service, in its third year of operation, served 20 county medical societies and 2 councilor districts.

Substantial financial support for the program came from Merck Sharp and Dohme Postgraduate Program, West Point, Pa. in the amount of $1,511.85. Other supporting organizations were the Wisconsin State Board of Health, American Cancer Society—Wisconsin Division, Wisconsin Heart Association, and Wisconsin Anti-Tuberculosis Association.

During its three years of operation, the Speakers Service has provided 204 speakers for 38 county medical societies.

CAREER BOOKLET TO HELP RECRUIT MEDICAL STUDENTS

"Your Career Opportunities in Medicine" is the title of a new 32-page booklet designed to help communities interest more students in careers in medicine.

Issued by Pfizer Laboratories and J. B. Roerig and Company, ethical drug divisions of Chas. Pfizer & Co., Inc., the booklet was prepared in cooperation with the Council on Medical Education and Hospitals of the American Medical Association and was checked for accuracy by the Division of Operational Studies of the Association of American Medical Colleges.

Copies of the booklet are being offered free to medical groups for distribution at health fairs and high school career day programs and to educational guidance counselors, science teachers, physicians and the public. They are available through the Education Services Department, Chas. Pfizer & Co., Inc., 235 East 42nd Street, New York 17, N. Y.

WPS Builds Reserves

A favorable balance of premiums received over claims paid resulted in $50,934 being added to the reserves of Wisconsin Physicians Service during August, according to a financial statement recently issued.

With an increase of $25,537 in the market value of securities, the total added to reserves of the health insurance division of the State Medical Society during the month comes to $76,471, bringing the total of reserves at the end of August to $2,126,877.

POISON CONTROL CENTERS SET UP IN WISCONSIN

Five poison information centers and 83 poison control centers have been established in 69 Wisconsin communities, according to a recent report by the University of Wisconsin Extension Division.

A poison information center is a hospital designated by the State Board of Health with an accumulation of reference materials, including the index cards furnished by the National Clearinghouse for Poison Control, in one specified area which is staffed and equipped to provide 24-hour-a-day information on ingredients of potentially toxic substances and to recommend and give treatment.

A poison control center is a hospital which has an accumulation of reference materials, not including the National Clearinghouse index cards, in one specified area and which provides readily available drugs, antidotes, appliances, and equipment necessary for the treatment of poisoning cases.

JOINT BLOOD COUNCIL DISSOLVES

Having successfully achieved its major goal of coordinating the existing national interests in blood, the Joint Blood Council, Inc. is being dissolved. Dr. Gunnar Gundersen, La Crosse, is the Council's president.

Within the past seven years a national peacetime blood program of major significance has been worked out under the leadership of the Council which is composed of representatives of the American Medical Association, the American National Red Cross, the American Hospital Association, the American Association of Blood Banks, and the American Society of Clinical Pathologists.

An excellent gift idea for Christmas or special occasions all year around—for your wife, husband, or friends associated with the medical profession.

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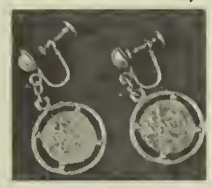
Authentic reproductions of ancient coins, crafted into exquisite jewelry for both men and women, cast in metal and silver plated.



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Commission on Aging Has New Executive Director and Offices

James F. McMichael, formerly director of the Lansing, Mich., Project on Aging from 1958 to 1962, is the new executive director of the Wisconsin Commission on Aging. He has assumed his duties in the Commission's new headquarters at 419 S.W. State Capitol Building, Madison.

Mr. McMichael, who has a B.A. degree in psychology and an M.A. degree in political science with a graduate minor in social work from Michigan State University, served as a public health field representative for the Michigan Department of Health, division of TB and adult health, from 1957 to 1958.

Patricia F. Lanier, M.D., Kewaunee, is vice-chairman of the Commission on Aging which is headed by Richard W. Bardwell, Ph.D., Madison. Doctor Lanier is a member of the State Medical Society's Division on Aging of the Commission on State Departments.

Functions of the Wisconsin Commission on Aging as put forth in Chapter 581 of the 1961 Legislature are:

1. To review state programs to develop an efficient overall program for the aging on the state level.
2. To examine the need for future programs and services on state, local, and voluntary levels.
3. To develop new programs for the aging in areas where such programs are needed.
4. To gather and disseminate information about the aging and the services available to them.
5. To stimulate public awareness and understanding of the needs and the potentials of the aging.

WPS Enrollment Increases

Wisconsin Physicians Service enrollment figures for September, recently released, show an increase of 1,046 surgical–medical, and 941 hospital contracts during the month.

This results in 113,538 surgical-medical, 45,867 hospital and 19,710 major medical contracts in force at the end of the month, a total of 179,115 contracts.

DELLS CLINIC DOCTORS GO ON DUTY AT GAMES

Physicians were urged by the House of Delegates in May to participate in sports injury prevention and control programs and county societies were requested to appoint interested physicians to serve high school athletic teams for a full season and attend all competitive events. A recent *Wisconsin Dells Event* commentary was:

"Doctors at the Dells Clinic have responded most graciously to a request from the local school to have a physician present at all home games—just in case.

"It was Dr. C. F. Broderick's turn Friday night and he responded most admirably on the one occasion he was pressed into service. One of the Nekoosa lads came up with a charley horse and proper medical assistance was quickly administered.

". . . the cooperation of the Clinic staff is sincerely appreciated by the school administration, the athletic department, and all followers of the 1962 Chiefs."

Ad Hoc Committee to Study Control Bills on Radiation Hazards

The Commission on Public Policy, which met October 14 at the State Medical Society headquarters in Madison, recommended the appointment of an ad hoc committee on radiation hazards to study the various proposals being made for state control of radiation hazards and to report its recommendations to the Council.

The Commission urged that the committee include in its considerations the qualifications of those permitted to use ionizing radiation.

In compliance with legislation passed by the 1961 Legislature, 3,375 radiation sources have been registered in the state. (Detailed figures appeared in the October *Journal.*) More than one person may use equipment under one registration, as in a clinic or hospital. More than one piece of x-ray equipment may be included under one registration.

Results of the survey are being used by the Industrial Commission and the State Board of Health as they prepare separate bills on the control of radiation hazards for action by the 1963 Legislature.

Arbitration Board on Malpractice Suits Eyed by Committee

Creation of an arbitration board with which to "arbitrate, prevent, and reduce the number of malpractice suits" was discussed by the Committee on Economic Medicine of the Council which met at the State Medical Society office September 30.

Health care of the aged in terminal illness and a survey of business practices of physicians also were discussed. Further study will be given to all three topics.

A tentative program for the Medical Economic Conference will be considered by the committee at its next meeting.

Members of the Committee on Economic Medicine are: Drs. J. H. Houghton, Wisconsin Dells, chairman; P. B. Blanchard, Cedarburg; D. M. Willson, Milwaukee; W. J. Egan, Milwaukee, president-elect of the State Medical Society; G. J. Schulz, Union Grove; and George Nadeau, Green Bay.

IOLA HAS NEW DOCTOR AFTER 4-MONTH SEARCH

The arrival of Dr. Charles E. Wood in Iola this fall ended the Waupaca county village's four-and-one-half-month search for a doctor.

Doctor Wood, a native of England, had been practicing medicine about a year in Morris, a central New York community of about 650 persons.

In April, when Iola lost its two resident physicians by death in two days, the State Medical Society helped arrange for area doctors and two Madison physicians to take turns at a seven-week resident term serving the village's hospital.

the Wisconsin Medical Journal

DECEMBER 1962

VOLUME 61

NUMBER 12

THE WISCONSIN SURGICAL SOCIETY

A Short History

By WARNER S. BUMP, M. D.

Rhinelander, Wisconsin

ONE JUNE 9, 1946, twelve Wisconsin surgeons met at Milwaukee to organize a statewide surgical association to be known as the Wisconsin Surgical Society. The committee on organization consisted of Doctors F. Gregory Connell of Oshkosh, Victor Marshall of Appleton, Arnold Jackson of Madison, Russell Kurten of Racine, J. W. McRoberts and Leslie Tasche of Sheboygan, Thomas J. Snodgrass of Janesville, Warner S. Bump of Rhinelander, and Carl Eberbach, Forrester Raine, Arthur Schaefer, and Irwin Schulz of Milwaukee. At this meeting tentative constitution and bylaws were drawn up; and Sept. 14, 1946, was chosen for the date of a general organizational meeting to be attended by qualified surgeons of the state who were invited to be founder-members.

Fifty-one surgeons accepted the invitation to form the new society, 39 of whom were present at the meeting on Sept. 14, 1946. These 51 founder-members were: Fin G. Anderson, Warner S. Bump, F. Gregory Connell, Rogers T. Cooksey, A. R. Curreri, Joseph C. Dean, Paul Doege, Carl W. Eberbach, C. A. Evans, G. S. Flaherty, Joseph W. Gale, James Garland, Stephen Gavin, Will B. Gnagi, Arne C. Gorder, Joseph Gramling, Jr., Gunnar Gundersen, Sigurd Gundersen, Sr., Clarence B. Hatleberg, George T. Hegner, Arnold Jackson, James Jackson, Merritt L. Jones, Joseph M. King, Russell M. Kurten, Kenneth E. Lemmer, George V. Lynch, Arthur J. McCarey, J. W. McGill, J. W. McRoberts, Victor Marshall, A. L. Mayfield, Peter A. Midelfart, Ralph Morter, Wayne A. Munn, T. S. O'Malley, L. W. Peterson, Lawrence D. Quigley, Forrester Raine, C. S. Rife, Edmund Schacht, Arthur Schaefer, E. R. Schmidt, Irwin Schulz, Joseph Smith, Thomas Snodgrass, F. A. Stratton, James Sullivan, Leslie Tasche, Frank D. Weeks, and Dexter Witte.

At this meeting a constitution and bylaws were formally accepted and officers were elected as follows: president—F. Gregory Connell, president-elect—Russell Kurten, secretary-treasurer—Warner S. Bump, recorder—Frank Weeks, and councilors—Thomas Snodgrass, Forrester Raine, Carl Eberbach, Arnold Jackson, A. L. Mayfield and Sigurd Gundersen, Sr.

On Nov. 9, 1946, the Articles of Incorporation for the Wisconsin Surgical Society were filed according to state statute and the new society started its official existence with its

avowed "business and purposes . . . the cultivation and the improvement of the science and art of surgery for the betterment of surgical care of the citizens of Wisconsin, and the promotion of closer professional and social relations of the surgeons of the state, and such other matters as may properly come within its sphere." Its first clinical meeting was held in Milwaukee on Nov. 15, 1946, with Dr. Frederick Coller of Ann Arbor as the guest speaker.

It is to be noted that before the founding of the Wisconsin Surgical Society there existed an organization known as the Wisconsin Academy of Surgery. This had grown out of a struggling organization formed by a small group in Milwaukee which was called The Milwaukee Society for Clinical Surgery. The name of this society was changed to the Wisconsin Academy of Surgery after a number of the profession outside of Milwaukee became appreciative of the potential value of a statewide surgical organization and became members of the "Academy." Because this society had no written objects, bylaws, or constitution, and no written or uniform requirements for membership, and because its loose organization seemed an impediment to success, its members voted to disband it and to form a new well conceived and properly implemented society with the officers and council of the disbanded society as a nucleus for a committee on organization to draft the structure of the new society. As stated earlier, this committee met on June 9, 1946.

The Wisconsin Surgical Society has proved to be the successful organization for which its founders hoped. It meets semi-annually with the main portion of its scientific programs contributed by its members and with special invitation by guest-participants who are often young surgeons and residents.

The membership list on May 10, 1962, included 164 surgeons of the state. At present Dr. Anthony R. Curreri is the president, Dr. Morrison Schroeder the president-elect, Dr. Norman O. Becker the secretary-treasurer, and Dr. Sigurd Gundersen, Jr., the recorder. The Council now consists of Doctors William H. Pollard, Jr., Marvin H. Steen, Victor S. Falk, Shimpei Sakaguchi, Wayne J. Boulanger, and Robert G. Wochos.

Past presidents from the society's inception are: Doctors F. Gregory Connell, Russell M. Kurten, Erwin R. Schmidt, Carl W. Eberbach, Warner S. Bump, Arnold S. Jackson, Joseph W. Gale, Forrester Raine, Frank D. Weeks, Sigurd B. Gundersen, Sr., Thomas J. Snodgrass, Joseph M. King, Kenneth E. Lemmer, James M. Sullivan, Peter A. Midelfart, and Jack A. Killins.

OBSERVATIONS ON THE EFFECT OF INTRAPERITONEAL FIBRINOLYSIN ON THE REFORMATION OF INTESTINAL ADHESIONS

By A. Stephen Close, M. D., W. Thomas Redfern, M. D., and Michael Polacek, M.D., Milwaukee, Wisconsin.

Intraperitoneal fibrinolysin has been suggested as a means of preventing postoperative adhesions. This study was designed to determine its effect in high dosage on the reformation of adhesions in dogs known to be adhesion formers.

Primary intraperitoneal adhesions in dogs were first produced: The ileum was obstructed by an umbilical tape ligature, the obstruction was released after 24 hours, and the entire small intestine rubbed vigorously with dry gauze. One square cm. areas of serosa were then removed from the intestine at 8 cm. intervals and the abdomen closed. On exploration three weeks later more than 70% of the animals had developed adhesions. The adhesions were graded from 1+ to 3+ and the incision was closed. Twelve of these animals then received intraperitoneal instillation of 10,000 u./Kg. of fibrinolysin in three divided doses over an eight-hour period (Group 1). Seventeen animals were treated with 30,000 u./Kg. of fibrinolysin in six divided doses over a two-day period (Group 2). Ten control dogs received similar quantities of saline.

At sacrifice three weeks later, the adhesions were again graded; only 5 of the 11 surviving animals in Group 1 and 3 of 12 surviving dogs in Group 2 had decreased adhesion formation. Four of 10 control animals had a decrease in adhesion formation.

Adhesions were produced without recourse to leaving foreign substances or bacteria in the peritoneal cavity of dogs, and there was no mortality associated with the production of adhesions. One-fourth of the animals did not form adhesions; and following simple surgical lysis in those who did, one-fourth were relieved of adhesions. Fibrinolysin had no effect on preventing reformation of intestinal adhesions.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

Intralobar Pulmonary Sequestration

By CHARLES BENKENDORF, M. D. and ROBERT G. WOCHOS, M. D.

Green Bay, Wisconsin

INTRALOBAR sequestration of the lung is a developmental anomaly of the cardiovascular and pulmonary systems. A lobe or bronchopulmonary segment is completely or partially separated from its normal continuity with the bronchial tree. The sequestered lung receives its blood supply from a systemic artery or arteries usually arising from the lower thoracic or upper abdominal aorta. The condition assumes clinical importance when infection supervenes and makes its differential diagnosis important from the standpoint of determining treatment. To the surgeon, this is significant because inadvertent section of the anomalous and abnormally located systemic arteries may result in serious hemorrhage.

EMBRYOGENESIS

The most controversial feature of this bronchovascular anomaly is the embryogenesis, and this largely remains a matter of opinion. Opinions differ as to whether the defect is primarily of the vascular or respiratory system.[1] The most widely quoted, and probably the most applicable theory, is that of Pryce[2] who believes that a systemic pulmonary artery persists in its fetal attachment to a portion of the lung and results in this portion of the lung separating from the main pulmonary mass. The resultant sequestered pulmonary tissue has no direct communication with the tracheobronchial tree. This abnormal segment of the lung usually lies in the base of a lower lobe, is incorporated within the visceral pleura, and is therefore called intralobar. It can less commonly exist as an anomalous extralobar sequestration, separated by pleura from the remainder of the lung and lying either above or below the diaphragm. The intralobar lesion frequently develops cystic changes, and the three cases presented here were all of this type.

Presented before the Wisconsin Surgical Society at the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

SYMPTOMS AND CLINICAL FINDINGS

The presence of intralobar sequestration may be discovered as an asymptomatic condition on routine chest x-rays. However, more commonly the lesion becomes clinically manifest when it becomes infected. The characteristic feature is one of repeated episodes of pneumonia limited to the same basal lung area and marked by intermittent cough, fever, chills, occasional hemoptysis, and pleuritic pain.[3] The productive cough usually means that the cystic area of the sequestered lung now communicates with the tracheobronchial tree as a result of infection. Thus the clinical course may be confused with that of bronchiectasis, lung abscess, empyema, or acquired infected cysts.

ROENTGEN MANIFESTATIONS

The roentgenographic findings are similar in most cases and are dependent upon the absence or presence of infection.[4] The lesion is usually an incidental finding if no infection is present. The appearance in the routine dorsal ventral view is that of a rounded or oval homogenous area of increased density in the posteromedial aspect of the lung base on either side. Occasionally, a finger-like projection from the mass is directed posteriorly and medially toward the aorta and represents the artery supplying the sequestered pulmonary tissue.[5]

There is usually enough bronchial communication present in the infected cases so that one or more air and fluid levels are visible in a uni- or multi-locular cyst. Infection in the adjacent pulmonary parenchyma occasionally masks the cysts which are usually thin-walled.

Bronchography invariably fails to demonstrate the bronchial communication in spite of the fact that air fluid levels indicate some communication between the cysts and the bronchial tree. Aortography has been used in some of the reported cases of others to demonstrate the abnormal systemic artery supplying the sequestered lung.

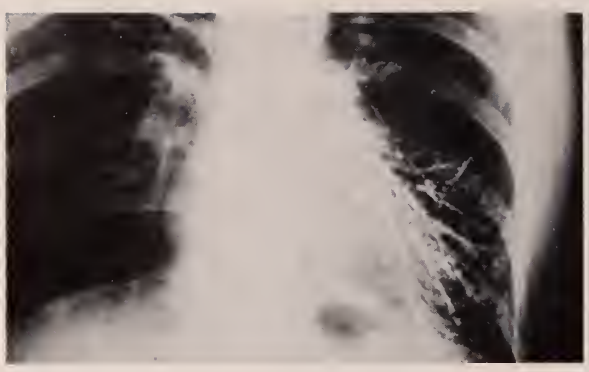

Fig. 1—Case 1. Left branchagram demanstrates a lack af cammunicatian between the unilacular cyst and the apacified branchial tree.

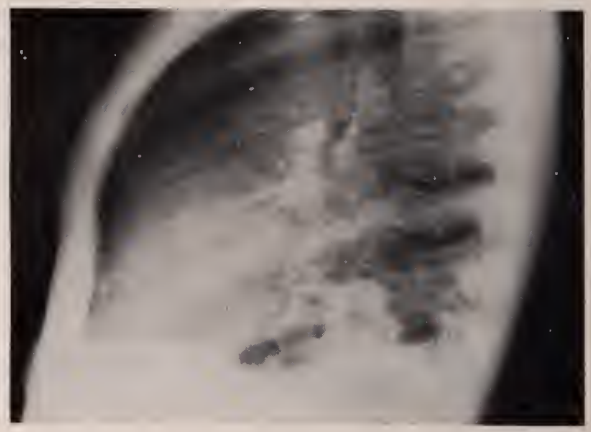

Fig. 2—Case 2. Lateral film af chest shows a multilacular cystic lesian and associated inflammatory infiltrate representing the sequestered segment.

TREATMENT

Treatment is surgical resection of the diseased pulmonary tissue. This usually necessitates lobectomy because of the intralobar location of the lesion. Although segmental resection is possible and was utilized in one of our patients, the technical problems that arise in attempting to separate the diseased and healthy lung in this area are considerable. The attempt to salvage a portion of the lower lobe seldom warrants the increased risk, and lobectomy becomes the operation of choice.

Preoperative suspicion of sequestration will alert the surgeon to the likelihood of the presence of the anomalous blood supply. The systemic pulmonary artery or arteries to the involved area are frequently located in the pulmonary ligament beneath the normal hilar structures. The vessels may be quite large and fairly short in their course from the aorta, and inadvertent cutting or tearing may lead to serious hemorrhage.[6] The venous return from the sequestered pulmonary tissue is usually through the normally located pulmonary veins, although drainage to the azygos system has been reported.

Lobectomy was accomplished in two of our patients and basal segmental resection in the third. All three had uneventful recoveries with clearing of pulmonary symptoms and no subsequent respiratory problems.

CASE REPORTS

Case 1. This was a 24-year-old woman with a history of intermittent chronic cough of 12 years' duration. Cough was productive and hemoptysis had occurred on at least one occasion. Mild exertional dyspnea and occasional left-sided chest pain were present. No childhood history of pneumonia or tuberculosis was obtained. Admission chest x-ray films showed a cavitary lesion with a fluid level in the left medial basal lung field. Bronchography revealed no filling in the area of this lesion. Bronchoscopy was negative except for thick mucoid sputum in the left lower lobe bronchus. At surgery, a typical intralobar pulmonary sequestration of the left lower lobe was found. An anomalous artery was located in the pulmonary ligament. It measured 0.7 cm. in diameter and pursued a short course from the aorta to the sequestered lung tissue. This artery could easily have been cut during division of the pulmonary ligament. The superior segment of the left lower lobe was normal, and in this patient a segmental resection of the basal segments, including the area of the lesion, was accomplished. The patient's postoperative course was uneventful.

Case 2. This was a six-year-old boy with a history of bouts of intermittent pneumonia for a period of 15 months. The episodes were marked by fever and productive cough. His development had been slow, his color pale, and his appetite poor. There was no history of aspiration of a foreign body. A review of x-ray films taken at another hospital showed an inflammatory process involving the posterior basal segment of the left lower lobe with associated radiolucent cystic areas. This same area was involved at the time of admission. Bronchoscopy was

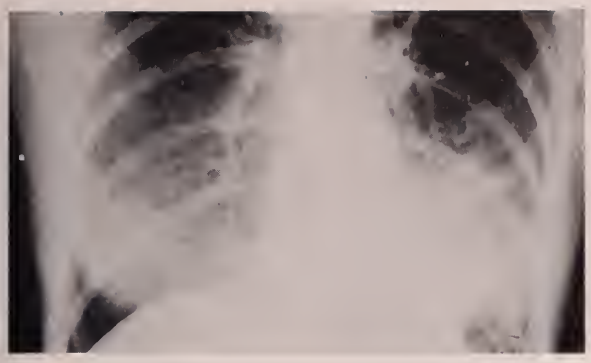

Fig. 3—Case 3. Posterio—anterior film of the chest demonstrates an inflammotory infiltrate on the left in the typicol basal location.

Fig. 4—Cose 3. Lateral film localizing the area of sequestration in the posteromedial aspect of the left lung.

essentially negative. Bronchography revealed no communication between the diseased area in the left lower lobe and the left bronchial tree. The radiological diagnosis was pulmonary sequestration or localized bronchiectasis. At operation, a left lower lobectomy was accomplished. At least three separate arteries from the distal thoracic aorta supplied the sequestered lung in the posterior basal portion of the left lower lobe. Dissection was difficult due to an extensive inflammatory reaction involving the hilar structures. At one point during surgery there was a spill of thick, bloody, mucoid material from the infected cystic area into the tracheobronchial tree which complicated anesthesia until the left lower lobe bronchus was controlled. The postoperative course was uneventful. The child gained 20 pounds in the next five months and has become healthy in comparison to his preoperative status.

Case 3. This was a 22-year-old woman presenting a history of chronic pulmonary infection since 1952. This was marked by frequent episodes of fever and productive cough. There had been a 20-pound weight loss. A chest x-ray film taken in 1959 had shown an abscess with a fluid level in the left lower lobe. X-ray studies on admission showed an inflammatory density localized to this same area. Bronchoscopy showed evidence of chronic inflammation with purulent secretions in the left lower lobe bronchus. A bronchogram revealed a lack of filling of the bronchi to the medial posterior basal segment in the region of the inflammatory infiltrate. A diagnosis of intralobar sequestration was made preoperatively. Surgery consisted of a left lower lobectomy. The surgeon reported marked inflammatory changes in the basal segments of the left lower lobe with adherence to the chest wall, diaphragm, and mediastinum. In this latter area, he reported several abnormal arteries arising from the aorta and running to the inferior portion of the lower lobe, typical of a sequestration. The patient's postoperative course was uneventful.

SUMMARY

A developmental anomaly of the lung known as intralobar pulmonary sequestration has been described. It consists of a portion of lung embryologically separated from continuity with the normal bronchial tree, located within a lower lobe, and possessing an abnormal arterial blood supply. Its embryogenesis, clinical significance, radiological features, and surgical treatment have been described. Three cases illustrating the lesion have been presented.

The authors acknowledge permission to include Case 3 in their case reports. This patient was under the surgical management of Dr. William Stoll.

St. Vincent Hospital.

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Torsion of the Hydatid of Morgagni (Appendix Testis)

Report of Three Cases

By LESLIE H. STONE, M. D.
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TORSION of the hydatid of Morgagni is an interesting though uncommon condition which is usually discovered upon exploration of the scrotum with a preoperative diagnosis of torsion of the spermatic cord.

The hydatid of Morgagni, or appendix testis, is a small, pedunculated, cystic structure arising from the upper pole of the testicle. It is present in approximately 90 per cent of normal males, and may be either sessile or on a short stalk. It is a remnant of the upper portion of the Müllerian duct, and may assume the appearance of the fimbriated end of a miniature fallopian tube, but is more commonly a simple cystic structure, which varies in size from 1 to 8 mm. in diameter. Microscopically, it is composed of vascular connective tissue covered by a layer of columnar epithelium which may or may not be ciliated.[1]

The appendix of the epididymis is a similar structure located at the upper pole of the epididymis and is often called the pedunculated hydatid of Morgagni, or the organ of Giraldes. This hydatid is found in approximately 27 per cent of normal males and is thought to be a remnant of the cephalic end of the Wolffian or mesonephric duct.

Either of these hydatids of Morgagni may become twisted on its pedicle, and infarction of the cyst may then occur. Torsion of the appendix testis was first reported by Colt[2] in 1922, and a review of the world literature through 1950 revealed 115 cases reported. Oeconomopoulos and Chamberlain[3] collected 26 cases from the files of Boston City Hospital from 1939 through 1959 and noted that 77 per cent of the cases gave a history of onset of scrotal pain during or following athletic activities. No cases in this series gave a history of direct scrotal trauma. Dix[4] observed that most cases of torsion involved large remnants, and felt that the size itself predisposed to torsion, whereas Oeconomopoulos and others have emphasized the length of the pedicle as the major contributing cause, feeling that the low incidence of torsion is probably due to the large number of hydatids which are sessile. Torsion may occur in any age group; however, approximately 90 per cent of reported cases occur between the ages of 2 and 16 years.

CASE REPORTS*

Case 1: An 11-year-old boy was admitted to the hospital with a complaint of pain and swelling of the right scrotum of two days duration. The pain began following a scuffling match, and had gradually increased until admission. There was no history of nausea or vomiting. An examination revealed that he was afebrile. The right scrotum was red and edematous; the right testicle was markedly enlarged and acutely tender. Transillumination revealed a large hydrocele. The hemoglobin level and hematocrit reading were normal. The white blood cell count was 12,350 with a normal differential count. The urinalysis was essentially normal. The patient was taken from the emergency ward to the operating room with a diagnosis of torsion of the spermatic cord. However, exploration revealed a torsion of the appendix testis. The hydatid was 7 mm. in diameter, gangrenous, and there was a large hydrocele filled with pink fluid. The testicle and the spermatic cord were edematous. The hydatid was removed, the tunica vaginalis closed, and recovery was uneventful.

Case 2: A 2½-year-old boy, was hospitalized with a two-day history of painful swelling of the right scrotum. His mother stated that he had fallen from his tricycle four days prior to admission and was thought at that time to have struck his scrotum. His appetite had been poor and he had been fussy since the fall. The child was found afebrile. Abnormal physical findings were limited to the right scrotum which was ede-

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*From Mercy Hospital.

matous, acutely tender and transmitted light. The spermatic cord was noted to be thickened. There was no palpable hernia impulse. The complete blood count was essentially normal. The urinalysis was normal.

The patient underwent surgery with a diagnosis of probable torsion of the spermatic cord. Exploration revealed marked edema of the spermatic cord and testicle with a moderate hydrocele. When the tunica vaginalis was opened, an infarcted appendix testis was found; it was approximately 3 mm. in diameter and gangrenous. The hydrocele fluid was reddish-brown in color. An indirect hernial sac was also discovered. The gangrenous appendix testis was removed, the hernia was repaired, and the postoperative course was uneventful.

Case 3: A 5-year-old boy was hospitalized with an admitting complaint of pain in the right testicle of four hours duration. There was no history of trauma. The onset of pain was sudden and the pain was increasing. Examination revealed him to be afebrile. Positive physical findings were limited to the right scrotum which was moderately edematous, and the right testicle which was slightly enlarged and acutely tender. An acutely tender spherical mass was palpable at the upper pole of the testicle. The complete blood count and urinalysis were normal. He underwent surgery with a diagnosis of infarction of the appendix testis. Exploration of the scrotum was carried out, and a gangrenous appendix testis, 5 mm. in diameter, was found and removed. This hydatid was on a very short pedicle, with one complete twist. The tunica vaginalis was closed after excision of the cyst, and the postoperative course was uneventful.

COMMENT

Torsion of the hydatid of Morgagni produces a sudden onset of pain with symptoms limited to half of the scrotum. This pain is similar although perhaps less severe than that due to torsion of the spermatic cord. Local swelling and tenderness of the scrotum occur within a few hours, and fluid collects in the tunica vaginalis forming a hydrocele which may make palpation of the hydatid impossible. Redness of the scrotal skin occurs in 36 to 48 hours, and the pain and swelling will persist for days or weeks if surgical excision is not done. Nausea and vomiting are seen infrequently with this condition, and the temperature is usually normal or very slightly elevated. If surgical excision of the hydatid is not accomplished, the cyst will go on to necrosis in most cases, although some may spontaneously untwist with relief of symptoms. However, these cases are apt to be followed by repeated attacks. Swenson[5] reports five cases in which a history of prior attacks of similar pain was obtained.

The differential diagnosis is concerned with distinguishing between torsion of the spermatic cord, epididymo-orchitis, and torsion of the appendix testis. It is frequently impossible to distinguish preoperatively between torsion of the appendix testis and torsion of the testicle; although if seen early before a large hydrocele and massive edema of the scrotum have occurred, the tense, acutely tender hydatid may be palpated at the upper pole of the testicle. If this is possible, the diagnosis of torsion of the appendix testis is secure. In most cases, however, exploration of the scrotum must be carried out to rule out torsion of the spermatic cord.

Gross[6] emphasizes the importance of opening the tunica vaginalis at exploration to carefully inspect for torsion of the hydatids if a frank torsion of the cord is not found at exploration. He reports that of 13 patients seen at Boston Children's Hospital, one 16-year-old boy had an orchidectomy with the erroneous diagnosis of torsion of the testicle only to find that on pathological examination, a gangrenous appendix testis was present with edema of the testicle and spermatic cord.

It is probable that many cases of torsion of the appendix testis go undiagnosed and are thought to be epididymo-orchitis in childhood. To support this thesis, Oeconomopoulos reports that within 20 days after a report of this condition was given to the resident staff at Boston City Hospital, 5 cases were diagnosed and surgery performed. Prehn[7] reports that it is helpful in distinguishing between epididymo-orchitis and torsion of the cord or appendix testis to elevate the scrotum. He points out that this relieves the pain of epididymo-orchitis, but does not relieve the pain of torsion of the testicle or appendix testis.

The treatment of choice is surgical exposure through an inguinal incision, with

inspection of the spermatic cord, testicle and epididymis by opening the tunica vaginalis. When the tunica vaginalis is opened, the appendix testis is seen as a bright red or dark red cystic mass lying at the upper pole of the testicle suspended by a short stalk in which one or more twists may be seen. Simple ligation of the pedicle and excision of the cyst is curative. A variable amount of serous or serosanguineous fluid may be found in the tunica vaginalis depending upon the duration of torsion and the advance of necrosis. Surgical correction of the hydrocele is usually unnecessary. Swenson recommends prompt exploration of all suspected cases because it gives prompt relief of pain, prevents recurrence of symptoms, and is required to rule out torsion of the spermatic cord.

SUMMARY

Three cases of torsion of the hydatid of Morgagni are presented. A brief discussion of the anatomy, etiology and differential diagnosis of torsion of the appendix testis is also given. Prompt surgical intervention is recommended for relief of pain, prevention of recurrence, and distinguishing between torsion of the spermatic cord and torsion of the appendix testis.

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THE HAZARD OF THE ASSOCIATED DIAPHRAGMATIC HERNIA IN PATIENTS OPERATED FOR ABDOMINAL DISEASE

By Wilson Weisel, M. D., Milwaukee, Wisconsin

The potential hazard of complications from esophageal hiatal diaphragmatic hernias under certain conditions of stress has been documented by serious morbidity seen as a result of this defect in 12 patients over a four-year period following general surgical procedures. The pathogenesis of reflux esophagitis catalyzed by operative stress and convalescent position can produce rapid development of esophageal obstruction and bleeding.

The best treatment is prevention of complications necessitating recognition of the lesion prior to abdominal surgery and repair of the defect when this course is feasible. Other important factors in the postoperative course are careful attention to general homeostasis, gravity drainage of the esophagus, avoidance of esophageal irritation, and reduction of gastric acidity and stasis. The complications in these patients illustrates the continuing need for careful physiologic appraisal of the individual patient in order to secure good surgical results.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Section of Thoracic and Cardiovascular Surgery, Marquette University School of Medicine, and Wood Veterans Administration Hospital, Milwaukee.

PULMONARY BIOPSY

Doctors R. R. Watson, Derward Lepley, Jr., and Wilson Weisel, from the Thoracic–Cardiovascular Section, Division of Surgery, Marquette University School of Medicine and Surgical Service, Wood Veterans Administration Hospital, Milwaukee, presented a paper on the diagnosis of systemic and pulmonic diseases having roentgen manifestation of diffuse bilateral pulmonary fibrosis at the nineteenth annual meeting of the Central Surgical Association, Cincinnati, February, 1962. The paper was subsequently published in *Archives of Surgery*, October, 1962.

They presented a series of 34 patients with diffuse fibronodular pulmonary disease and an alveolar-capillary block syndrome in whom a definite diagnosis could be made only by pulmonary biopsy. The advantages of obtaining a definite histological diagnosis in these patients was evidenced by the institution of specific therapy, restitution of employability, return of patients to family life, proof of industrial relationship, avoidance of unnecessary therapy, and hospitalization and proof of otherwise undiagnosed malignancy.

They concluded that pulmonary biopsy could be an efficient and safe procedure in the diagnosis of difficult pulmonary problems. Thirteen pathological entities were diagnosed in the 34 patients having pulmonary biopsy.—V. S. Falk, M. D.

Anterior Cervical Fusion in the Management of Cervical Spine Fracture-Dislocation

By EUGENE E. HERZBERGER, M. D.

Monroe, Wisconsin

THE USE OF anterior cervical fusion has been a great step forward in the management of patients with cervical spine fracture-dislocation. The main purpose of anterior cervical fusion in these patients is a stabilization of the spine which will allow early ambulation and will assist in early clinical recovery.

In our opinion, anterior cervical fusion is not meant to replace the procedures of cervical spine decompression which have been in use for many years. If there is evidence of cervical cord and cervical nerve root compression by fracture-dislocation, head traction by means of Crutchfield tongs should be instituted. If this procedure does not produce a lessening or complete recovery of the neurological deficit, a laminectomy and decompression of the spinal cord may be necessary. However, once the cervical cord has been decompressed and the cervical spine dislocation reduced to some extent by traction, early and effective stabilization of the cervical spine must be accomplished.

In the past, traction by means of Crutchfield tongs and other means was continued over a long time, sometimes four to eight weeks. After that period, when the patient finally was allowed out of bed, he had to wear a heavy collar or even a plaster cast for an additional six to eight weeks. The use of anterior cervical fusion has simplified the management of these patients considerably, as will be noted from this case presentation.

The technique of anterior cervical fusion, as described by Smith and Robinson,[1] is followed quite closely in our clinic. Under general anesthesia, a transverse incision about 1½ inches long is made on the left side of the neck and is carried through the platysma and cervical fascia. The sternohyoid, sternothyroid and omohyoid muscles, the trachea, and the esophagus are retracted medially and inferiorly while the sternocleidomastoid muscle is retracted laterally. Since only a slight lateral retraction is required, there is no trauma on the carotid artery. The anterior longitudinal ligament is then exposed along with the proper intervertebral space. To be certain that the location is correct, a No. 20 gauge spinal needle is inserted into the intervertebral space and a lateral roentgenogram is taken. After proper identification, a transverse incision is made through the anterior longitudinal ligament over the interspace. The intervertebral disc is completely removed.

The excision of the cartilaginous plates is carried out well laterally in order to involve the joints of Luschka on both sides. The cortical bone of the vertebral body within the interspace is partly removed. A full thickness bone graft is taken from the iliac crest. It consists of cancellous bone surrounded on three sides by cortical bone. The graft is shaped to fit the interspace but is slightly larger in size. Gentle head traction is applied by the anesthesiologist as the graft is inserted with the proper amount of pressure. Then the wound is closed without drainage.

The postoperative course is usually uneventful with ambulation starting on the day after surgery. Cervical support is unnecessary, except in those patients who have had a laminectomy for a fracture-dislocation and in those patients who have required anterior interbody fusion at more than one level. Such patients must wear a collar for six to eight weeks.

The Smith–Robinson type of anterior cervical fusion used by us is a very different operation from the anterior cervical fusion

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Fig. 1—Lateral raentgenagram taken immediately after admission of the patient to the haspital, showing fracture–dislacatian C_5–C_6.

Fig. 2—Lateral cervical raentgenogram taken 12 haurs after traction with Crutchfield tangs, shawing that the fracture–dislacation C_5–C_6, althaugh less marked, has nat been adequately reduced.

practiced by Ralph Cloward of Honolulu.[2] The Smith–Robinson operation is a much simpler one, and in our opinion its greatest merit consists in spine stabilization, rather than in the cervical cord and nerve root decompression intended by Cloward.

Anterior cervical fusion also has proved itself to be an effective operation in a variety of syndromes due to cervical disc degeneration and herniation. This problem has been presented in detail in another publication.[3]

CASE REPORT*

A 20-year-old farmer was injured in a trampoline accident on Mar. 19, 1961. Immediately after the accident he was unable to move either upper extremity and felt considerable numbness in them. He was able to move his lower extremities, although they also felt somewhat numb. Immediately after the accident he was transported to a hospital where roentgenograms of the cervical spine (Fig. 1) showed a fracture-dislocation at C_5-C_6.

*From The Monroe Clinic.

Neurological examination revealed considerable functional impairment of both upper extremities. The patient could flex the fingers of both hands very slightly, but he could not move his hands at the wrists or extend his fingers; he could not move his elbows, but he was capable of slight movement at the shoulders. The reflexes in both upper extremities were absent. There were sensory changes varying from a severe hypesthesia to complete anesthesia, starting in the C_4 nerve root dermatome and ending in the T_1 and T_2 nerve root dermatomes on both sides. There were bilateral extensor plantar responses; the abdominal skin and remaster reflexes were absent on both sides. The reflexes in the lower extremities were diminished. The patient was able to move his lower extremities quite well and could void. Crutchfield tongs were applied immediately with a traction of 22 pounds. Over a period of 12 hours there was no improvement. On the contrary, the patient felt more numbness in his lower extremities, became almost unable to flex his fingers, and developed further decrease in sensation in

Fig. 3—Lateral roentgenogram taken one day after anterior cervical fusian C_5–C_6, showing complete reduction of fracture–dislocation C_5–C_6 and goad alignment of the cervical vertebrae.

Fig. 4—Lateral raentgenogram taken seven months following anterior cervical fusion, shawing an advanced degree of fusian at C_5–C_6 and narmal curvature af the cervical spine.

the affected dermatome areas. Cervical roentgenograms at this time (Fig. 2) showed that the dislocation had not been adequately reduced. Therefore, it was decided that a cervical cord decompression by laminectomy should be performed.

The patient, lying prone on a Stryker frame, was operated upon under general anesthesia. Traction by means of Crutchfield tongs was maintained during the operation. A laminectomy involving C_4, C_5 and C_6 was carried out with foraminotomy of C_5-C_6 and C_6-C_7 on the left side. The dura was not opened. Normal pulsation of the dura was observed at the completion of the procedure. The muscles and the skin were closed in layers without drainage. The patient made a good recovery from this operation; and the day following surgery he was able to move his hands, to extend his fingers slightly, and to flex and extend his forearms. The intensity of the sensory changes lessened. Within three days' time there was remarkable improvement in the sensation and motor function of both upper limbs.

During this time the patient was maintained in Crutchfield tongs on a Stryker frame. It was then decided to stabilize his neck by an anterior interbody fusion at C_5-C_6 for earlier ambulation. Therefore, on Mar. 24, 1961, the fifth day after the accident and the fourth day following laminectomy, an excision of the C_5-C_6 intervertebral disc was carried out by the anterior approach, and an anterior interbody fusion at the same level was performed using a bone graft from the right iliac crest. Good stability of the spine was obtained immediately after introducing the bone graft into the interspace. (Fig. 3).

The patient was allowed to ambulate the day following the operation. He wore a collar while out of bed. When he rested in bed and supported his head on a pillow, no collar was used. He was discharged from the hospital three days after the fusion. He discontinued the use of the collar after six weeks at home. Two and one-half months after the operation the patient recovered normal strength in both upper extremities. He started to work on his farm at that time, and he has continued to lead a normal life. Postoperative roentgenograms (Fig. 4) showed good alignment of the spine.

SUMMARY

The role of anterior cervical fusion in the management of cervical spine fracture-dislocation has been discussed. A patient who sustained a fracture-dislocation C_5-C_6, with cervical cord compression, was treated by laminectomy followed by anterior cervical fusion C_5-C_6, which allowed him to be ambulatory on the sixth day after his accident. A complete functional recovery occurred in this patient. The anterior cervical fusion, in our opinion, has the role of cervical spine stabilization in order to allow early ambulation and recovery, and it is not used for purposes of cervical cord decompression.

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one of a series

ROENTGEN RIDDLE . . .

Fig. 1—Abnormal position of the distal deep concavity of the carpal lunate which is directed anteriarly or ventrally.

Fig. 2—Normal position of the distol deep concovity of the carpal lunate accepting the globular head of the capitate.

HISTORY: A 25-year-old white male tripped and fell on his outstretched right hand. Extreme pain in the wrist was followed by numbness and tingling of his index and mid finger.

PHYSICAL EXAMINATION: The right wrist was tender to palpation although no detectable crepitation was evident. Limitation of motion was present as well as a defect in the dorsum of the wrist and a swelling presented anteriorly.

Prepared by A. M. Richter, M.D., resident in radiology at Milwaukee County Hospital, under direction of John R. Amberg, M.D., radiologist, Department of Radiology at Milwaukee County Hospital.

DISCUSSION on page 618

CASE REPORT

Excision of Metastatic Carcinoma of the Liver with Seven Years Survival

By VERNON J. HITTNER, M. D.
Seymour, Wisconsin

THIS IS THE report of a patient who had a resection of the ascending colon for carcinoma and resection of a portion of the right lobe of the liver for metastatic carcinoma.[1-3] He is alive, working and apparently completely well seven years later.

This 42-year-old man was hospitalized in October, 1955. He complained of having abdominal distress and rectal bleeding for several months. Acute symptoms were only of two weeks duration when he became weak and a severe anemia was found. He had an appendectomy 11 years before.

PHYSICAL EXAMINATION

There was tenderness in the right side of the abdomen and about the umbilicus. X-ray studies of the upper gastrointestinal tract revealed no abnormality. However, barium enema studies revealed an annular, ulcerating carcinoma of the proximal ascending portion of the colon. His hemoglobin level on admission was 10 gm. per 100 ml. and the red blood cell count was 3,070,000.

The preoperative diagnosis was carcinoma of the ascending colon. The postoperative diagnosis was the same with metastatic nodule in the right lobe of the liver.

TREATMENT

Surgery performed on October 28, 1955, consisted of resection of the distal ileum, cecum, ascending colon, hepatic flexure, and a portion of the transverse colon. An end-to-side anastomosis was made. The metastatic nodule in the right lobe of the liver was resected.[1-3] Several large mattress sutures of chromic catgut were placed by means of a long flexible probe through the liver about the area to be excised. A large wedge of the liver with the metastatic nodule at the center was excised. The previously tagged sutures were then tied with a large piece of Gelfoam between the cut surfaces of the liver.

From St. Vincent's Hospital, Green Bay.

GROSS PATHOLOGY

Five centimeters above the proximal end of the cecum and extending along the long axis of the colon for a distance of 7 cm. was a single, almost completely annular, ulcerative lesion which formed a narrow, tortuous lumen. On cut section this ulcerative lesion varied in thickness from 6 mm. to 1.6 cm. and extended throughout the entire wall. There was no direct extension into the mesocolon, but the mesocolon adipose tissue contained numerous enlarged lymph nodes, several of which grossly had the appearance of metastatic, malignant lymph nodes. The specimen from the liver contained a single, irregularly rounded mass of yellowish white friable tissue occupying approximately 70 per cent of the volume of the specimen. This grossly had the appearance of a metastatic malignancy.

MICROSCOPIC PATHOLOGY

At the site of the lesion of the colon the normal glandular mucosa had been replaced by hypertrophic atypical epithelial cells which assumed a glandular form and which infiltrated all coats as far as the serosal coat. These atypical cells had destroyed and replaced the muscularis. Many of these cells showed complete degenerative change. The viable cells predominated and exhibited approximately 1 to 3 mitotic figures per high-power field.

Sections through pericolonic lymph nodes showed a hyperplasia of the lymphoid follicles and stroma but showed no evidence of malignant invasion. Sections through the liver showed atypical glandular epithelium replacing the liver parenchyma. These

atypical epithelial cells were similar in appearance to those of the lesion of the colon. This metastatic lesion had been partially walled off by fibrous tissue.

PATHOLOGIC DIAGNOSIS

1. Ulcerative annular adenocarcinoma of colon with metastases to liver, Grade 3.
2. Hyperplastic pericolonic lymphadenitis.

COMMENT

The patient was discharged from the hospital after two weeks. He has worked steadily since his recovery. Examination seven years later, on Sept. 17, 1962, revealed no evidence of recurrence of the carcinoma.

The case is reported to demonstrate the value of excision of a solitary metastatic nodule in the liver.

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UNUSUAL PSEUDOCYSTS OF THE PANCREAS

By Robert C. Brault, M. D., Milwaukee, Wisconsin

Complications of pancreatitis, particularly pseudocyst, are often present in the guise of colon, gastric, or pulmonary problems. Four brief case reports may serve to illustrate such problems and point the way toward their solution:

1. The first patient was admitted and studied for a left pleural effusion, developed a bronchopulmonary fistula and empyema. Not until after supra and subdiaphragmatic drainage procedures did a thoughtful resident obtain amylase studies of the drainage and establish the diagnosis of pseudocyst.

2. The second patient was admitted for terminal care for widespread carcinoma manifested by gastrointestinal symptoms and bloody pleural effusion. The correct diagnosis of pseudocyst and associated pleural effusion was made on the basis of the history and physical examination, and the patient was successfully treated.

3. This patient was admitted because of large bowel symptoms. A diagnosis of splenic flexure obstruction due to pseudocyst was made, and at surgery multiple small cysts and marked fibrosis were found throughout the left upper quadrant. Resection of pancreas, spleen, and colon gave a good result.

4. The fourth patient illustrated the reverse situation. Jaundice and an epigastric mass were thought to represent biliary tract obstruction due to pseudocyst of the pancreas. Operation demonstrated common bile duct obstruction secondary to "sludge," and the mass was an area of omental fat necrosis.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and the Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

PERFORATION OF THE COMMON BILE DUCT

By Robert G. Brault, M. D., Milwaukee, Wisconsin

A 50-year-old white man was admitted to the hospital with a twelve-hour history of mid left upper quadrant pain with radiation to the back. Admission examination revealed minimal epigastric tenderness, a temperature of 99 F. and moderate subjective pain. The white blood cell count was 18,000 and the serum amylase 600 units.

A diagnosis of probable acute pancreatitis was thought most likely, and the patient was treated by nasogastric suction, intravenous fluid and plasma, and antispasmodics.

During the following 15 hours, he developed increasing right upper quadrant pain and suddenly exhibited signs of generalized peritonitis.

At surgical exploration he was found to have extensive choledocholithiasis and cholecystolithiasis and minimal pancreatitis. The diffuse peritonitis was due to bile exiting from a spontaneous perforation of the common duct, 1 cm. distal to the junction of common and cystic ducts. The gallbladder was normal, the common duct cleared, and a T-tube placed within the common duct. The postoperative course was uneventful, and after four months of drainage the T-tube was removed.

Review of the English literature revealed 21 previously reported cases of spontaneous perforation of the common duct with an overall mortality rate of 65 per cent.

The condition is associated with acute inflammation of the biliary tract and associated lithiasis in 69 per cent of cases. Thirteen per cent are associated with acute pancreatitis and 9 per cent with parasitic infestation.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the Stae Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

Reappraisal of Tetanus Prophylaxis

By SAMUEL B. HARPER, M. D.

Madison, Wisconsin

TETANUS CAUSED more deaths in Wisconsin in the last four years than there were cases among the United States Armed Forces during the four years of World War II.* Because an active immunization program offers nearly perfect immunological protection, it is the purpose of this report to reappraise some of the problems involved in providing tetanus prophylaxis in civilian life.

Four elements are involved: (1) active immunization with recall tetanus toxoid at time of injury; (2) proper management of the wound; (3) passive immunization when indicated; and (4) administration of appropriate antibiotics. While, in theory, all four elements are within the realm of practicability, there are qualifying factors which account for the wide disparity between civilian and military statistics as it pertains to the incidence of tetanus. Active immunization may not have been completed or maintained. There may have been failure on the part of the patient to seek medical care prior to the development of tetanus. Sensitivity to alien protein in available antitoxin may have compromised passive immunization or precluded the use of antitoxin. Tetanus may also develop in a significant number of cases without any known injury.

The care of the wound, while not the particular concern of this report, must be understood to involve not only the whole field of surgery for trauma but also a thorough understanding of what constitutes adequate wound cleansing and debridement, as well as a willingness to employ delayed closure of contaminated wounds where indicated. Proper wound care is often compromised by delay on the part of the patient until the wound has become infected or tetanus has developed. However, the ubiquitous nature of the tetanus bacillus places a responsibility on the physician, which is frequently out of proportion to the severity of the wound.

The use of a booster dose of tetanus toxoid as prophylaxis presumes that the patient has completed an active immunization program. Active immunization does not exist until both the initial series of one or two monthly injections and the final recall injection, 6 to 12 months later, have been completed. Injuries occurring 6 months after the first series will be protected in varying degrees by the administration of the final recall injection at that time. Tetanus-prone injuries, under such circumstances, require additional protective treatment.

It is often difficult to determine whether the criteria for active immunization have been met. Most young adults living in Wisconsin have completed their immunization program in childhood, but many are often unaware of the nature or number of injections. Some pediatricians feel that there is a significant number of children who do not complete their childhood immunization program. If doubt exists as to the completion of the active immunization program, one must assume that no active immunization has been provided, and institute appropriate measures on that basis. The concept of partial immunity is not tenable.

In the 17 years since World War II, an increasing number of service personnel, who had been actively immunized, have not had boosters or interval injections of toxoid. While it appears that time has not yet outdated this original immunization, the time of appearance of circulating antitoxin following a recall injection is delayed, and individual responses vary. Until the degree and duration of protection afforded by this original immunization can be determined, additional measures should be employed if a 10-year interval has intervened since the last booster injection.[1]

The actively immunized patient is protected for at least one year, and probably longer, without administration of additional booster injections. It is important to recognize that additional injections of toxoid are not required during the year following the

Presented before the Wisconsin Surgical Society at the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

* Reported deaths from tetanus in Wisconsin are incomplete since primary cause of death (e.g., injury) obscures tetanus as a complication or contributing cause.

last booster injection. Too frequent injections of tetanus toxoid carry the risk of sensitization to toxoid and may actually defeat the purpose of providing protection.[2,3]

There is no evidence that the use of tetanus toxoid in the nonimmunized, injured patient provides any protection against the development of tetanus. Measurable levels of antitoxin do not appear until 14 days after the first dose of toxoid. The incubation period of fatal tetanus is usually less than 10 days. The specious hope that some form of natural immunity can be recalled by an initial dose of toxoid is not warranted. Since tetanus does not confer immunity and second cases of tetanus have been recorded, the use of toxoid predicates prior completion of the basic immunization program.

It is in the nonimmunized patient with a wound that the physician faces his greatest problems. A casual survey of a number of hospitals and physicians in Wisconsin indicates that there is a wide difference of practice regarding the administration of tetanus antitoxin. The incidence of reaction to the alien protein present in antitoxin derived from either equine or bovine sources has been estimated by Toogood to be 265 times the risk of tetanus.[4] These reactions are not entirely comparable with a disease as serious as tetanus which carries a mortality varying from 30 to 60 per cent. However, fatal reactions do occur and have been reported following even the test dose of diluted antitoxin given intradermally. In about one-fourth of the cases receiving a prophylactic dose of antitoxin serum, serum sickness occurs in varying degrees. In addition, there exists a variety of serious and bizarre reactions involving multiple systems and often attended by severe and permanent disabilities.[1,4,5,6] In the face of the high incidence of reactions, one cannot be casual in administering tetanus antitoxin.

The customary practice of utilizing small amounts of diluted antitoxin intradermally or on the conjunctiva, does not always enable one to predict the likelihood of a subsequent reaction to the alien protein. At some risk, it will indicate hypersensitivity which will preclude administration of antitoxin. It has been shown that the hypersensitive individual destroys alien protein and the antitoxin at an accelerated rate, thus compromising the amount of protection obtained.[7] Prior administration of horse serum accelerates the rate of destruction of the foreign protein and antitoxin in the absence of any anaphylactoid phenomena. The practice of giving repeated, small doses of antitoxin at intervals of several days is similarly associated with an accelerated rate of destruction which compromises the amount of protection received.

While elaborate schedules for "desensitization" of the patient are commonly available, the foregoing observations have prompted Lyons to conclude that passive immunization cannot be assured by a second dose of a foreign serum-containing antitoxin.[2]

Further confusion has been provided by the increasing recognition that the classic dose of 1500 immunizing units (I. U.) of tetanus antitoxin provides minimal protection for about one week. Tetanus has been reported to develop in a significant number of patients receiving this dosage.[6] In an effort to provide more adequate protection, it has been suggested frequently that the prophylactic dose of antitoxin be increased to 3000, 5000, or even 10,000 I. U. This increase of antitoxin and the accompanying alien protein is associated with an increase in anaphylactoid phenomena which, in turn, may compromise the amount of protection.

Before attempting to formulate a program for providing specific tetanus prophylaxis, the use of antibiotics should be mentioned. Experimental work indicates that the tetanus bacillus is susceptible to a number of antibiotics; namely, penicillin, tetracycline, and chloramphenicol. It is, as yet, uncertain whether data obtained from current animal studies can be applied to humans since susceptibility to infection, sensitivity to antitoxin, and levels of antibiotics and antitoxin may not be comparable.[7] Clinical programs employing extensive use of antibiotics and a minimal use of antitoxin are under study in a number of institutions with significant preliminary success.[6,7] Since the use of antibiotics is directed at the organism and has no effect on tetanus toxin, its use must be confined specifically to the period immediately after injury before any toxin has been formed to be of value. Antibiotic therapy should be continued for at least one week, or until the progress of wound healing is such that factors promot-

ing the growth of anerobic bacteria are eliminated. One clinical program has successfully utilized a single dose of 1,200,000 units of long-acting penicillin for a period of five years.[7]

A rational program for providing appropriate tetanus prophylaxis can be accomplished by a didactic appraisal of each patient. It is well to appreciate that some wounds are more prone to be associated with tetanus than others. The cleanly incised, relatively superficial wounds, yielding to good wound management, carry a minimum risk of tetanus. On the other hand, wounds seen after considerable delay, contaminated with soil, containing foreign bodies, anatomically inaccessible to appropriate wound care, or grossly infected, must be considered to be tetanus prone. On this basis it then becomes a matter of judgment on the part of the physician to decide whether the risk of tetanus exceeds the risk of giving appropriate, specific prophylaxis. In Charity Hospital of New Orleans, where the endemic rate of tetanus is very high, approximately 14 per cent of the wounds seen in nonimmunized patients are deemed to require the use of antitoxin.[8]

Following an appraisal of the wound, the status of the immunization of the patient should be determined. The actively immunized patient, who has had a booster injection in the past 10 years, requires only a booster injection of 0.5 ml. of fluid toxoid if seen within 24 hours of the injury. If the injury is over 24 hours old, circumstances relating to the nature of the wound may dictate additional measures in the form of antitoxin. If there is doubt concerning the active immunity, waning active immunity in the absence of booster injections within 10 years, or no active immunity, protective measures other than the use of toxoid are indicated.

In the nonimmunized patient where it has been decided on the basis of the nature of the wound that passive immunization is indicated, acceptable protection can be provided by the use of tetanus antitoxin, acknowledging the risks and limitations previously mentioned. For patients who, by selection, are deemed less likely to react unfavorably, the administration of from 3000 to 5000 units of antitoxin is the recommendation of most authors.[6] This dose may be halved for children and should be doubled for injuries over 24 hours old.

It should be recognized that the merits of trying to predict untoward serum reactions are only relative, and that reactions cannot be entirely eliminated in spite of marked improvement in the purification of the various available antitoxin preparations. The patient with a known allergic diathesis, a history of previous serum reaction or even of antitoxin administration, or a sensitivity to the intradermal or conjunctival test dose, runs an increased risk of having an untoward reaction and uncertain protection. As an alternative, the patient may be tested for sensitivity toward bovine-derived antitoxin, although cross-sensitivity limits this procedure.

There is also available in limited amounts tetanus-immune gamma globulin prepared from hyperimmune human donors.[9] The high cost and limited availability restrict its general usage. Another effective means of protection is provided by a plasma transfusion from an actively immunized donor who has received a booster dose of toxoid one month previously.[2] Since some of these alternative procedures are not always available or practicable, it may become necessary to rely on the use of antibiotics, again recognizing that the protective value of antibiotics lies in early administration prior to the formation of any tetanus toxin. This latter course, as previously stated, is new and is based on sound experimental evidence from animals. It is undergoing clinical trials in a number of institutions at present. As yet, it lacks the approval of the Council on Therapeutics of the American Medical Association and the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.[10] It is recommended by Lyons in a summary of endorsed practices of the American College of Surgeons and of the American Association for the Surgery of Trauma. It is given as the alternate method of choice by one leading authority in a popular annual text on current therapeutic methods.[11]

In reviewing reports of tetanus cases, both individual and collected, one can note that penicillin or other antibiotics have been administered to a number of patients prior to the development of tetanus. In evaluating the apparent failure of antibiotics to afford protection under such circumstances, it is necessary to know more about the dosage,

time of administration, and duration of therapy.

Active immunization can and should be instituted at the same time passive immunization is provided. If one recognizes that the administration of tetanus antitoxin derived from alien sources compromises the value of its use in the future, it becomes essential to good medical practice to take advantage of the current opportunity to start active immunization. It would appear that no incompatability exists if separate syringes and, preferably, a different extremity is used. There is some hesitancy to initiate active immunization immediately in severe tetanus-prone injuries requiring large amounts of antitoxin. Since hospitalization is usually required under such conditions, the first dose of toxoid can be delayed for several days. Completion of the active immunization program becomes a joint responsibility of the physician and the patient. A small appointment card with a brief explanation of the program and appropriate dates for subsequent completion of the program could be a part of every hospital emergency room routine. It has been my experience, as well as that of others, that patients are inclined to forget the last injection unless reminded by the physician.

CONCLUSIONS

A reappraisal of current problems in achieving tetanus prophylaxis brings out several points worthy of emphasis:

1. Currently maintained active immunization in conjunction with proper wound care provided almost complete protection against the development of tetanus. Too frequent administration of tetanus toxoid should be avoided.

2. Thoughtful selection of cases in conjunction with proper wound care can avoid the indiscriminate administration of tetanus antitoxin and unnecessary sensitization phenomena.

3. When tetanus antitoxin is indicated, the dosage should be in the range of 3000 to 5000 I. U. Ordinarily, excessive dosage should be avoided.

4. Simultaneous initiation of active immunization in conjunction with the use of tetanus antitoxin usually should be started, and it is the joint responsibility of the physician and the patient to complete the program.

5. Two means of providing temporary, passive immunity utilizing human sera are available.

6. Certain antibiotics have a place in the tetanus prophylactic program which has not yet been determined. At the present time, reliance on antibiotics in tetanus-prone injuries should be confined to those patients seen very soon after injury, and in whom the use of foreign protein, passive immunization is contraindicated.

1 South Pinckney Street (3).

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A summary of fundamental procedures for providing safe and effective tetanus prophylaxis is presented on the opposite page. It is recommended that physicians clip this summary for future reference. Requests for reprints on poster paper for posting in hospital, clinic, or physician emergency areas may be sent to the State Medical Society of Wisconsin, Box 1109, Madison 1, Wisconsin.

Summary of Fundamental Procedures For Providing Safe and Effective Tetanus Prophylaxis

A. PROPER WOUND CARE

1. Primary defense against tetanus.
2. Involves all principles of surgery of trauma including thorough cleansing, debridement of necrotized tissue, and removal of foreign material.
3. Use delayed primary-secondary closure when indicated.
4. Recognize tetanus-prone injuries where additional prophylactic measures are indicated.

B. TETANUS TOXOID

1. Provides *no* protection in absence of prior basic immunization.
2. Booster dose within 24 hours of injury provides almost complete protection in individuals who have completed basic immunization.
3. If in doubt as to completion of basic immunization, treat as if no immunity exists.
4. Individuals with basic immunization and a booster dose in past 12 months do not require additional booster of toxoid at time of injury except under extreme circumstances.
5. Too frequent use of toxoid may produce sensitivity phenomena and compromise immunity provoked.
6. Basic immunization without additional boosters is good for at least ten years and probably much longer.
7. Initiate active immunization program at time of injury in unimmunized individuals and provide schedule for follow-up completion of program. When given at a different site with a clean syringe, simultaneous use of toxoid is compatible with ordinary doses of antitoxin.

C. TETANUS ANTITOXIN

1. Should be reserved for tetanus-prone injuries in patients lacking active immunization or where completion of active immunization is in doubt.
2. A *thorough inquiry into possible allergies* in patient or family and of previous administration of serum of alien origin is as important as sensitivity testing.
3. Standard procedures for intradermal or conjunctival testing *must* precede administration of tetanus antitoxin, recognizing that testing is not without some hazard and that immediate and delayed reactions can occur without evidence of sensitivity to the test dose.
4. In the presence of serum sensitivity the degree and duration of passive immunity provided by tetanus antitoxin may be compromised.
5. Previous administration of antiserum in the past and in the absence of serum reaction may be attended by an accelerated rate of destruction of any tetanus antitoxin with a resultant compromise in protection.
6. When indicated, tetanus antitoxin should be administered in a dosage range of 3,000 to 5,000 International Units. Smaller dosage in adults may not provide adequate protection, and larger dosage increases the risk of reaction.
7. The use of tetanus antitoxin should be viewed by the physician as a once in a lifetime procedure, repetition being avoided by using the occasion to initiate active immunization.

D. USE OF ANTIBIOTICS

1. Experimental evidence and extensive clinical trials indicate that one injection of long-acting penicillin (1.2 million units) *given within three hours* following injury will provide satisfactory protection. Tetracycline and chloramphenicol in full dosage continued for one week appear to provide similar protection.
2. Until the use of antibiotics for tetanus prophylaxis becomes a more generally accepted procedure, their use might be reserved for those unimmunized individuals with tetanus-prone injuries for whom the administration of equine or bovine-derived antiserum carries an unwarranted risk of sensitivity reaction.

CLINICOPATHOLOGIC CONFERENCE

Sponsored by Section on Pathology
State Medical Society of Wisconsin

Guest Editor: MURRAY A. LITTON, M. D.
Rhinelander, Wisconsin

CASE PRESENTATION*

This 74-year-old white man entered the hospital because of abdominal cramps, nausea, and vomiting. Three days before admission he had severe, generalized cramps which lasted all afternoon. The cramps subsided the following morning, but in the afternoon the patient became nauseated and began to vomit brownish liquid. The vomiting and generalized abdominal soreness continued, but no cramping was present on admission. The patient had felt abdominal distention during the past year. Bowel habits had been normal. There was a recent deliberate weight loss of 20 pounds. Twenty-five years ago the left kidney was removed because of stones. The family history was noncontributory.

Physical examination revealed a well developed and nourished, acutely ill man. His blood pressure was 120/60 mm. Hg., pulse 70 and respirations 16 per minute, and temperature 100.2 F. The abdomen was slightly distended. There was slight peristaltic atonia throughout the abdomen, but no spasm was noted. Tenderness was present in the left lower quadrant, and there was questionable generalized rebound tenderness. No masses were palpated.

The patient's hemoglobin level was 15.3 gm. per 100 ml., hematocrit reading 50%, white blood cell count 13,350 with 44 band cells, 30 segmented forms, 14 lymphocytes, and 12 monocytes. Urinalysis revealed a trace of albumin, 3+ sugar, few bacteria, 3 to 4 white blood cells, and 3 to 4 red blood cells per high-power field. The blood glucose was 145 and urea nitrogen 34 mg. per 100 ml., the serum sodium 133 and potassium 3.85 mEq./l.

A roentgenogram of the chest revealed no pertinent abnormality other than a large fluid level below the left diaphragm. Roentgenograms of the abdomen in supine and upright projections showed a striking absence of gas in the colon. A number of small, flat, almond-shaped gas shadows with fluid levels were noted mainly in the left upper quadrant of the abdomen. A round, soft tissue density measuring 5 cm. in diameter also could be identified in the left upper quadrant, which was interpreted to represent a fluid-filled loop of the jejunum. These findings suggested the presence of a high small intestinal obstruction. A small calculus was also suggested in the inferior pole of the right kidney.

The patient was treated with fluids intravenously and nasogastric suction. There was 1600 ml. of brownish liquid aspirated. The liquid did not have a fecal odor. A laparotomy was performed on the morning following admission. The patient's postoperative course was uneventful, and he was discharged 32 days after admission.

*From St. Mary's Hospital.

DIFFERENTIAL DIAGNOSIS

Dr. Vernon Bartley: Three days prior to admission the patient experienced severe generalized cramps. By the following day nausea and vomiting of brown liquid had occurred, together with onset of general abdominal soreness. Abdominal distention had been noted by the patient. He also had sustained a planned weight loss.

Left nephrectomy was performed for nephrolithiasis in 1937. Physical examination on admission showed an acutely ill man with indirect evidence of dehydration (blood pressure 120/60 and hematocrit reading 50%). His temperature was 100.2 F., pulse 70 per minute and respirations normal. Left lower quadrant tenderness with possible generalized rebound tenderness, indicative of early peritoneal irritation, was noted. Bowel sounds were atonic and distention, indicative of ileus secondary to the peritoneal irritation, was present. No masses were palpated, but one can not always feel

a mass when distention and localized guarding enter the clinical picture.

Laboratory evidence of an elevated white blood cell count, with a shift to the left, further supports an early abdominal inflammatory process. Urinalysis findings are consistent with the known history of nephrolithiasis, coupled with low-grade urinary tract infection. Blood urea nitrogen is definitely raised, but the serum chloride level was not mentioned in spite of the degree of vomiting. (Serum chloride level was not requested.)

X-ray films show an absence of colonic gas with evident distention of the small intestine, the latter having fluid levels chiefly localized in the left upper quadrant. A questionable calculus appeared in the inferior pole of the right kidney.

The patient was treated supportively on admission in order to accomplish a safer laparotomy. This precaution is highly commendable.

The evidence points to a clinical diagnosis of high small intestinal obstruction progressing through the stages of simple occlusion (abdominal cramps, nausea, and vomiting), strangulation (peritoneal signs), and later neurogenic obstruction (peristaltic atonia). High occlusive obstruction can be caused by factors within the intestine (foreign bodies, gallstones, polypoid tumors, parasite masses), disease in the intestinal wall (atresia, tuberculosis, regional ileitis, strictures, or tumor), or pressure on the intestine from without (adhesions, bands, internal hernia, enlarged nodes, inflammatory or neoplastic masses).

(a) Factors within the intestine:

There is no history of foreign body ingestion nor of parasitic disease. Gallstone ileus usually causes a low small intestinal obstruction because the offending stone impacts in the terminal ileum. Furthermore, x-ray films showed no gas in the biliary tree, and there was no tenderness over the gallbladder. Polypoid tumor of the jejunum is a real possibility especially with the year-long history of noticeable distention, the acute episode of obturation giving rise to a high obstruction as supported by radiological evidence including demonstration of a soft tumor mass 5 cm. in diameter.

(b) Disease in the intestinal wall:

It is rather late in life for the first symptoms of stricture, atresia, or regional ileitis to present. Tuberculosis of the intestine is usually secondary to pulmonary tuberculosis, of which there is no historical or radiological evidence. Again tumor of the intestinal wall is a possibility; either leiomyoma, leiomyosarcoma, or lipoma. Gastroenteric cyst with communication and ensuing obstruction at the neck of the cyst could predispose to obstruction of the main intestinal lumen.

(c) Pressure on the intestine from without:

Adhesions and bands are unlikely since presumably the left nephrectomy was extraperitoneal. Enlarged nodes would suppose a primary tumor which one might expect to cause local symptoms before the occurrence of secondary involvement from metastatic growth. Inflammatory cause such as diverticulitis would have been more readily available from history. Neoplasm, extrinsic to and involving the jejunum, also must be entertained. Other possibilities are internal herniation, mesenteric thrombosis, and reflex ileus due to renal stone. Internal herniation of bowel in one of the paraduodenal fossae can be strongly considered. Mesenteric thrombosis is unlikely because of the history of cramping pains and no evident cardiac arrhythmia. Renal stone ileus does not give rise to such a localized obstructive picture with absence of colonic gas.

In conclusion, my first clinical diagnosis is a polypoid tumor of the jejunum; and second, internal herniation of small bowel in a paraduodenal fossa.

OPERATIVE FINDINGS

Dr. George Pratt: A small, constricting tumor was found in the midjejunum. The intestine proximal to the tumor was dilated, and the intestine distal to the tumor was collapsed. No lymph node metastases were palpated. Approximately eight inches of

small intestine were removed on either side of the tumor, and an end-to-end anastomosis performed. The patient withstood the procedure well, and his postoperative course was uneventful.

PATHOLOGICAL DISCUSSION

Dr. Murray A. Litton: The specimen consisted of a segment of small intestine 30 cm. in length. There was a mass, 3 cm. in length, 4 cm. in width, and 1.6 cm. in thickness, 10 cm. from the lower resection end. The overlying serosa was thickened and retracted. The mass was cup-shaped with a firm, gray-white sectioned surface. It invaded the entire wall of the intestine and partially obstructed the lumen. The circumference of the intestine proximal to the tumor was 7 cm., distal to the tumor it was 4 cm. Microscopic examination of the tumor showed a primary adenocarcinoma of jejunum. The tumor had a distinct glandular pattern, and there was invasion of the entire intestinal wall. No metastases were found in the mesenteric lymph nodes.

Adenocarcinomas of the jejunum and ileum are considered to be rare tumors. In 1950, Pridgen et al.[1] found more than 500 cases reported in the literature. The same authors reported 63 cases of primary adenocarcinoma of the jejunum and ileum from the Mayo Clinic. Of the 63 tumors, 44 were primary in the jejunum. In these patients the symptoms were classified into the anemic, obstructive, and the perforative syndromes. Partial or complete obstruction of the small intestine was the most common clinical finding. Roentgenologic studies of the small intestine are helpful and will be diagnostic in most cases. The treatment of choice is wide resection of the tumor and removal of regional lymph nodes.

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INTRA-ABDOMINAL ABSCESS: REVIEW OF ONE HUNDRED CONSECUTIVE PATIENTS

By A. Stephen Close, M. D., and Wm. T. Redfern, M. D., Milwaukee, Wisconsin

The clinical records of 100 consecutive patients with 141 intra-abdominal abscesses have been critically reviewed. The more significiant findings were as follows:

1. More than 70 per cent of the patients had complications other than abscess, most of these complications occurred early and usually produced fever. As a result fever was usually apparent within two days of surgery and was of limited value in making timely and accurate diagnosis.

2. Fifty per cent of the patients had significant hypotension immediately before, during, or after major surgery preceding the abscess. This feature is consistent with experimental studies showing that low blood volume or flow lessens resistance to bacterial invasion.

3. Sixty per cent of the patients underwent operations of longer duration than four hours.

4. Regardless of the operation performed, one of every three abscesses was anatomically distant from the operative site.

5. Intestinal obstruction or ileus was present on x-ray films in 30 per cent of the patients with abscess. Its presence was of limited value in diagnosis and did not appear to influence mortality. The x-ray film was least helpful in pelvic, paracolic, and subhepatic abscess.

6. Intestinal fistula preceding or following surgical drainage of abscess was associated with a 50 per cent mortality rate.

7. Cultures of nose, throat, rectum, intestine and prophylactic drain sites identified the organism subsequently found in the abscess in only 15 of 70 patients. Empiric choice of antibiotic combinations including chloramphenicol, streptomycin, and colomycin, or oxytetracycline would be effective in about 90 per cent of the patients. Penicillin might have been effective (in terms of laboratory sensitivity of the organism) in 10 per cent of the patients; yet, it was the most commonly used antibiotic—ordinarily being administered "prophylactically," or in treatment of possible spreading intraperitoneal infection.

8. The mortality rate for postoperative intraperitoneal abscess was 25 per cent.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

SPECIAL TO THE JOURNAL

Fallout Surveillance

By WILLIAM L. LEA, Ph. D.

Director, Radiation Protection Division
Wisconsin State Board of Health

MADISON, WISCONSIN

AS LONG AS MAN has lived on the earth he has had a continuous 24-hour per day exposure to ionizing radiation. This exposure is commonly referred to as background exposure and comes from two main sources. One source is ionizing radiation given off from the sun which traverses space, penetrates our heavier partially shielding atmosphere, and irradiates the earth. The second main source is radiation given off from radioactive material in the earth's crust. The combined annual cumulative exposure from these sources is fairly uniform throughout the United States. However, in some areas of the West and Southwest the background exposure of residents may be as much as double, or even triple, the annual dose rate in Wisconsin due, in part, to the higher elevation and, in part, to the presence of more radioactive material in the earth's crust in these areas. Since the gamma rays constituting our background radiation are identical in nature to the gamma rays emitted by fission products in fallout, it is evident that the radiation exposure from weapons testing fallout is not something new or different but simply an addition to a radiation exposure which is always present.

Research and development work on nuclear weapons has been in progress ever since the development of the first atom bomb. This continuous program is necessary in the interest of national security. Nuclear weapons testing is an essential part of this development program since theoretical improvements in design must eventually be tested. Fallout of radioactive material from thermonuclear weapons testing becomes distributed over the earth's surface by prevailing winds and simply constitutes an additional radiation exposure to the background radiation exposure normally present.

Early studies clearly showed that the additional radiation from fallout material deposited on the earth's surface did not measurably increase our external background radiation exposure. Fallout from nuclear weapons testing does not present an external radiation problem but rather a potential internal exposure problem due to ingestion.

In the United States, both federal and state programs have been established and are currently carrying on sampling programs to determine the magnitude of this additional exposure due to ingestion of foods containing radioactive material from nuclear weapons testing fallout.

The Federal Radiation Council, a group of this nation's topflight radiation specialists, was formed as an advisory group to the President and to the federal agencies concerned with public radiation problems. As an aid in evaluating this additional fallout exposure, the Federal Radiation Council has established standards of acceptable intake for the principal radioisotopes present in fallout from nuclear weapons testing. These standards are conservative and were established at levels calculated to be low enough to protect one-year-old infants, the most sensitive individuals in our society. In establishing safe or acceptable standards, the Federal Radiation Council established ranges of concentration or activity of radioisotopes in foods rather than single arbitrary values. These standards are used by public health agencies throughout the nation to evaluate public exposure to fallout from peacetime nuclear weapons testing programs.

Range I is the lowest standard. As long as the concentration of any radioisotope per unit weight of food lies within this range, there is no cause for concern and only normal routine food sampling need be conducted.

Range II is the second standard. As long as the concentration of any radioisotope lies within this range, only an increased food sampling program is necessary to obtain more information from more sampling points to serve as a sound basis for evaluation.

Range III is the third standard. Whenever the concentration of any radioisotope

lies within this range for a prolonged period of time, usually a year, a decision must be made on the most practical control measures to be applied to reduce the dietary intake of a particular radioisotope and the public must be advised of the problem and the necessity for controls to reduce the intake.

Data on the concentration or activity of radioisotopes in foods is secured nationwide from a surveillance system operated by the United States Public Health Service. In addition, many states have established more intensive surveillance systems of their own.

The Wisconsin State Board of Health has established a surveillance system to measure the concentration of radioisotopes from nuclear weapons testing in three segments of our environment—air, surface water supplies, and foods. The air is continuously monitored, since this data serves as a valuable index to the amount of radioactive material which may later appear in our food. The major surface waters, some of which serve as public water supplies, are routinely sampled once a month to determine their radioisotope content. Milk, a major food, is sampled at weekly intervals from the principal milk-producing areas throughout the state.

Data from the radioisotope surveillance system of the Wisconsin State Board of Health is compiled and compared with the universally used standards established by the Federal Radiation Council. Through the continuous operation of this surveillance system and evaluation of the data in terms of acceptable levels of ingestion, the public will be protected from any potential hazard resulting from nuclear weapons testing fallout.

POVIDONE-IODINE FOR PREOPERATIVE PREPARATION OF SKIN

By Miles P. Smith, M. D., A. Stephen Close, M. D., and Marie Koch, Ph. D., Milwaukee, Wisconsin

During alternate months two methods of skin preparation were compared over a two-year period. One method consisted of hexachlorophene liquid soap and aqueous zephiran chloride (1:1000) for the patients' skin and hexachlorophene soap for the surgeons' hands. The other method consisted of a povidone-iodine detergent followed by 1% aqueous povidone-iodine for preparation of the patients' skin and the surgeons' hands. The study included cases from general surgical, thoracic, orthopedic, and neurosurgical services; but all operative procedures with known or highly probable contamination from sources other than skin were excluded.

In the hexachlorophene group the wound infection rate was 3.2% compared to 2.7% in the povidone-iodine group. Infection rate is low in such a group of operations with any method of skin preparation, so conclusions are based primarily on the incidence of skin reactions and bacteriologic data. Minor skin reactions were seen more frequently in the hexachlorophene–zephiran patients. Four nurses or surgeons reported dermatitis apparently due to hexachlorophene soap compared to one local reaction to povidone-iodine. Post scrubbing fingertip cultures of surgeons were sterile in only 21% of 42 instances (average of 13 colonies) with hexachlorophene, and were always sterile with povidone-iodine. Postoperative fingertip cultures were sterile almost four times as often with povidone–iodine and averaged only one-fourth as many colonies. Similar results with cultures of patients' skin were obtained.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

CHORISTOMA OF THE BILIARY TRACT

By Bruce F. Stengel, M. D., Milwaukee, Wisconsin

Only five cases of choristoma of the biliary tract have been reported; recognition of this entity is therefore of chiefly academic interest, and it presents no features to the clinician serving to distinguish it from other causes of biliary tract obstruction. This case was operated for such obstruction, diagnosed clinically and by frozen section as carcinoma of the biliary tract, and treated by radical resection and choledochojejunostomy. Postoperatively, the diagnosis of a benign neoplasm of the biliary tract composed of well-differentiated mucosal, neural, and smooth muscle elements was made; and the stomach was identified as the source of this developmental error by a combination of special staining techniques.

Abstract of paper presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

Effects of Low Molecular Weight Dextran in Three Experimental Conditions

I. EFFECT OF LOW MOLECULAR WEIGHT DEXTRAN ON EXPERIMENTAL HEMORRHAGIC SHOCK

By Joseph Bowler, B. S., Derward Lepley, Jr., M. D., Robert Schmidt, B. A., Ross C. Kory, M. D., A. Stephen Close, M. D., and Michael Weisfelt, B. A., Milwaukee, Wisconsin

Low molecular weight dextran (LMDX) has proven effective in maintaining patency of the micro circulation in traumatic shock and following occlusion of the superior mesenteric vein. These findings suggested the need for investigation of the effect of LMDX in hemorrhagic shock.

Thirty mongrel dogs were lightly anesthetized with thiopental anesthesia. A cannula was placed in a femoral artery for bleeding and to monitor systemic pressure. They were then bled rapidly to an arterial pressure of 40 mm. Hg. pressure. After 10 minutes at this level, they were divided into two groups by random selection. In one group (controls) 15 ml./Kg. of the extracted blood was reinfused rapidly. In a second group (treated) 15 ml./Kg. of LMDX was reinfused. After 20 minutes, to allow complete mixing, all animals were again bled to 40 mm. Hg. and held at this level by repeated small hemorrhages until decompensation occurred. At this point, all were reinfused with small amounts of blood to maintain a 40 mm. Hg. pressure until 20% of the total bleeding volume had been reinfused. All remaining blood was then returned minus the amount of dextran infused in the treated animals.

Animals receiving LMDX had a 28% greater bleeding volume, took longer to decompensate, showed an improved survival time, and took longer to take up 20% of the bleeding volume as compared to the controls.

In view of these findings, a second study was done. Eight dogs in each group were subjected to hemorrhagic hypotension in an identical experiment except that a cutoff point was selected at the mean time of hypotension of the control group in the first series. Although the bleeding volume was again much greater in treated animals, over 60% of these survived as compared to 40% in controls.

These findings suggest that the administration of LMDX prevents or minimizes "sludging" in the capillary beds during hemorrhagic shock and that vital organ perfusion is improved.

Abstracts of papers presented at the morning session of the Wisconsin Surgical Society during the 121st annual meeting of the State Medical Society of Wisconsin, Milwaukee, May 10, 1962.

From the Division of Surgery, Marquette University School of Medicine, and Surgical Service, Wood Veterans Administration Hospital, Milwaukee.

II. INFLUENCE OF LOW MOLECULAR WEIGHT DEXTRAN IN EXPERIMENTAL ACUTE OCCLUSION OF THE SUPERIOR MESENTERIC VEIN

By Derward Lepley, Jr., M. D., Milwaukee, Wisconsin

If patency of the collateral bed could be maintained following thrombosis or occlusion of the mesenteric vein, chances of survival would be increased. Since low molecular dextran has been shown to prevent sludging and cellular aggregation of blood in a variety of pathologic conditions, its effect on the prevention of mesenteric infarction following venous occlusion has been evaluated:

Forty-five dogs underwent temporary occlusion of the superior mesenteric vein. During the first hour of occlusion all animals received 20 ml./Kg. of a test solution; Group I (15 animals) received normal saline, Group II (15 animals) was infused with high molecular dextran, and Group III (15 animals) was given low molecular dextran. The occlusion was released at the end of the second hour and the abdomen closed.

Blood pressure fall and hematocrit elevations were pronounced in the control group, of lesser and variable extent in those receiving high molecular dextran, and negligible in the dogs treated with low molecular dextran. All dogs receiving saline (Group I) developed infarction and died. The animals given high molecular dextran (Group II) manifested some degree of infarction and three-fourths died. There were no infarctions in those treated with low molecular dextran (Group III), and only two died.

It is concluded that low molecular weight dextran is of considerable value in maintaining patency of the capillary bed and collateral circulation following venous occlusion of the dog intestine.

III. EFFECT OF LOW MOLECULAR WEIGHT DEXTRAN ON INFARCTION FOLLOWING EXPERIMENTAL OCCLUSION OF THE MIDDLE CEREBRAL ARTERY

By A. Stephen Close, M. D., Lawrence L. Foster, B. S., Dwight H. Brown, B. S., Andrew E. Cyrus, M. D., Milwaukee, Wisconsin.

The extent of brain damage resulting from acute arterial occlusion is related in part to arterial spasm and ischemia in areas adjacent to that supplied by the occluded artery. Occlusion of the micro circulation due to cellular aggregation (sludging) may occur in such areas during markedly diminished flow secondary to arterial spasm. Low molecular weight dextran, by preventing sludging, maintains the patency of the collateral venous drainage following occlusion of the superior mesenteric vein, thereby preventing infarction and

death; conceivably, it could play a similar role in acute arterial occlusion.

In 16 small mongrel dogs the middle cerebral artery was occluded for two hours during which 9 animals received 15 ml./Kg. of low molecular weight dextran intravenously, and 7 animals received no treatment. All 9 treated animals were conscious and alert within 24 hours, 8 walked within 48 hours. In contrast, 2 untreated dogs died and 2 remained unconscious until autopsy; 2 walked on the fourth day, 3 responded but never walked. At sacrifice, massive infarction of the brain with extension through the caudate nucleus and basal ganglia was found in each control dog. In contrast, infarctions found in dogs treated with low molecular weight dextran were distinctly lesser in extent and the caudate nucleus and basal ganglia were involved in none.

These findings suggest that the administration of low molecular weight dextran during periods of temporary cerebral arterial occlusion may prevent or diminish necrosis of the brain.

ROENTGEN RIDDLE

Continued from page 604

DISCUSSION: Dislocations of the carpal lunate bone, although certainly not as common as fractures of the wrist, are frequently overlooked and treated as severe sprains. Early identification and treatment prevents prolonged disability. Various types of dislocations involving the carpal bones are possible. The most common types, however, are the anterior lunate dislocation (case presented) and posterior perilunar dislocation with or without a complete transverse fracture of the carpal navicular. Anatomically, if the lunate maintains its normal position with the distal radius while the remaining carpus and hand is displaced, a perilunar dislocation is present. These are frequently associated with fractures of the navicular bone and styloid processes of the distal radius and ulna.

The accepted concept on the mechanism of lunate dislocation is that following severe hyperextension of the wrist plus force directed along the direction of the radius and ulna, the capitate-lunate ligaments are disrupted. The rounded dome-shaped proximal end of the capitate is then forced up and over the cup-shaped distal surface of the lunate. In perilunar dislocations the mechanism of hyperextension is similar; however, the carpal lunate maintains its position with the distal radius.

Roentgenographically, the normal lunate can be identified easily on the posteroanterior projection. It is generally quadrilateral in shape and located articulating with the distal radius on the ulnar side. Distally it articulates with the capitate and hamate. On the lateral projection the deep concavity of the distal lunate is appreciated as well as its position in relation to the capitate.

In lunar dislocations, the PA roentgenogram reveals the lunate to be pie-shaped or triangular rather than quadrilateral. The lateral projection provides conclusive evidence of lunar dislocations. Here the distal deep concavity of the carpal lunate is directed anteriorly or ventrally and not in its normal position

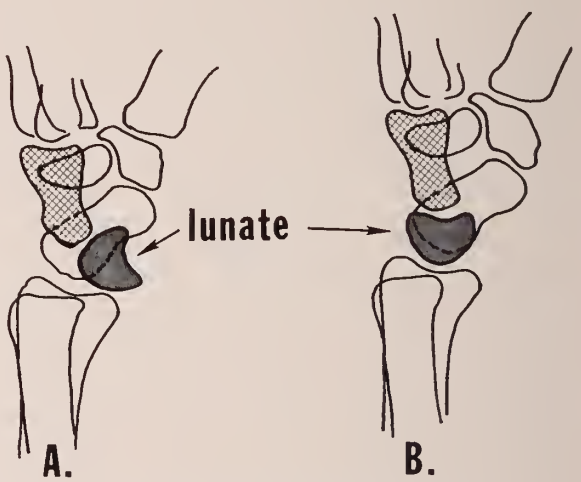

Fig. 3—Diogram illustroting positions shown in Figures 1 ond 2.

accepting the globular head of the capitate. Once the relationship between the distal radius, carpal lunate and carpal capitate are known, the diagnosis is not difficult and early treatment can be instituted.

Complications of an unrecognized dislocation of the lunate, besides that of continued pain and disability, are those of lunate aseptic necrosis and the carpal tunnel syndrome. The latter is a peripheral neuropathy, the result of chronic compression of the median nerve by the lunate as it traverses beneath the transcarpal ligament. It is characterized by paresthesia or anesthesia of the thumb, index and middle finger. This may be quite prominent. As time goes on flattening of the thenar eminence is evident with weakening of the abductor pollicis longus and the opponens pollicis muscles.

The treatment of lunate dislocations is immediate reduction. Various methods are available and all are based on the principle of applying traction to the capitate prior to reduction of the lunate bone. Old dislocations (past 3 to 6 weeks) are best treated operatively.

USE AND ABUSE OF ANTIBIOTICS IN SURGICAL PATIENTS

By William A. Altemeier, M. D., Cincinnati, Ohio, Christian R. Holmes, Professor of Surgery and Chairman of the Department at the University of Cincinnati, Director of Surgical Services at the Cincinnati General Hospital, and Surgeon-in-Chief at Children's and Holmes Hospitals, and John H. Wulsin, M. D., Cincinnati, Ohio, *Journal of the Michigan State Medical Society*, 61:851-858 (July) 1962.

The widespread use of antibacterial agents in the prevention and treatment of surgical infections has exerted a profound effect on the practice and progress of surgery. The miracles that have followed the use of antibiotics have been widely publicized, and many surgeons have come to believe that the prevention and control of postoperative infections are no longer important problems. The basic principles of asepsis and antisepsis which permit the prevention of infection in elective surgical wounds have frequently been neglected, and blind reliance has often been placed on the effectiveness of antibiotics used prophylactically. This practice has brought into sharp focus the obvious limitations of chemotherapy in the prevention of infections and has emphasized the present problem in postoperative wound infections.

The indiscriminate use of prophylactic antibiotic drugs has been a major cause of the increase in bacterial resistance to these drugs, particularly in the case of the hemolytic *Staphylococcus aureus* and the various gram-negative bacteria, which are frequent causes of serious wound infections. The continued use of specific antibiotic agents has increased the incidence of strains resistant to those agents.

Hospitals have become reservoirs of antibiotic-resistant and virulent bacteria in patients, physicians, and other personnel who develop infections or become carriers of resistant strains. These resistant strains may infect new hospital patients, particularly those who are debilitated or unusually susceptible through cross infection or superinfection. Thus, hospital-acquired infections may be particularly virulent and difficult to cure. The prevention of hospital-acquired infections, including postoperative wound infections, depends not upon the primary use of prophylactic antibiotic therapy, but upon established principles of isolation of infected individuals, aseptic and antiseptic techniques during and after operations, and good housecleaning. Unnecessary, inadequate, or ineffective antimicrobial administration contributes to the growth of antibiotic-resistant microorganisms.

Hospital personnel with established staphylococcal infections should be excluded from the operating room, nursery, laundry, and other areas of contact with patients, while carriers of the same epidemic strains of staphylococci as those found in local hospital infections should be treated with appropriate antibacterial drugs while being temporarily excluded from the operating room.

Antibiotic therapy cannot be expected to prevent local infection in wounds of violence or in operative wounds if established surgical principles or important technical details have been ignored. A gradual relaxation of the "surgical conscience" is manifested by carelessness in many details of *aseptic technique* in the operating room and at the bedside, and by discontinuation of *isolation technique* for patients with virulent infections. The "exposure method" of treating wounds and burns appears to have aided in the emergence and dissemination of virulent and resistant bacteria in the hospital environment and thence into other wounds.

In the surgical treatment of wounds of violence, the intelligent prophylactic use of antibiotics is adjunctive therapy and of secondary importance to early and adequate operative removal of devitalized tissue and foreign material. The main benefit of this therapy lies in the attenuation, limitation, or control of infection from residual microorganisms in such wounds after debridement and operative repair, or in the localization of any infection developing within wounds in which surgical treatment was necessarily inadequate, delayed, or impossible.

Systemic prophylactic antibacterial therapy is recommended for all patients with serious wounds of violence, such as major soft tissue wounds, compound fractures, injuries of the flexor tendon sheaths, penetrating wounds of the abdomen or of the thorax or of the central nervous system, injuries of the mouth and pharynx, and injuries of the perineum. The need for this therapy should be reconsidered after 72 to 91 hours. For patients in shock, the antibacterial drug should be administered intravenously because of poor absorption from the gastrointestinal tract and from subcutaneous tissues.

The correct clinical diagnosis of the injury, the selection of a proper and safe antibiotic agent, the determination of an adequate dose, and the mode of administration are important points in proper antibiotic therapy. The local use of antibiotics in fresh wounds, including burns, is not advised.

Complications which may occur as a result of antibiotic therapy include: (1) toxic reactions in various organs; (2) allergic reactions, as seen with penicillin; (3) secondary or superimposed infections by bacteria developing resistance during chemotherapy with a change in bacterial flora of the wound or of the gastrointestinal tract; (4) masking of latent infection so that the usual signs and symptoms are suppressed; and (5) the development of fungus infections which may become particularly difficult to control.

THE PRESIDENT'S PAGE . . .

Peace on Earth

EVERYONE PAUSES at this time of the year to recall former Christmas seasons, with the well remembered feeling of peace and calm that prevails then. Some of this comes from the closeness of friends and family more intimately felt at this time: but, most of it stems from an inner feeling of security, closely related to our religious observance of the feast of the Nativity, with the oft repeated, "Peace on Earth."

When we consider that a large part of our practice deals with patients who are suffering from the stresses, strains, and frustrations of daily situations, it would be a boon to all if we could extend the spirit of the season to include the whole year. Besides actual physical distress, some of our ills arise from mental conflict. The recent Mental Health Congress emphasized our growing interest in this field. If we can assuage the patient's feeling of foreboding and instill a sense of security, occasionally no further medical treatment is indicated. At other times, the sympathetic and understanding physician needs all of the armament of the new drugs to help him produce a calm and relaxed effect. Whether with counselling alone, or with medication, the alleviated patient can face his future with understanding and peace of mind.

We, as physicians, can recall the patients whom we have helped to overcome stresses; and we hope that they, as well as ourselves, can enjoy the holiday season with the prayer, "Peace on Earth, Good Will to Man."

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EDITORIALS

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On Guard

AS THE WORLD passed through the preelection Cuban crisis, people on both sides of the Iron Curtain suffered an acute case of jitters lest a thermonuclear holocaust mushroom over their heads in the very next minute. The fear was justifiable, and it is to be hoped, indeed, that we never approach that chilling possibility so closely again—either in fact or fancy.

If we do, however, let us be prepared for every type of warfare, not merely radiologic destruction. It is common knowledge that both the United States and her enemies have developed weapons of chemical and bacteriological warfare that can accomplish the purpose of nuclear explosions more easily, less expensively and with less danger to the user. Ranging from "incapacitants," which render populations helpless for specific periods of time, to fatal agents that can destroy every living thing in vast areas, chemical warfare has reached a level of sophistication equal with thermonuclear weaponry. Nor is it a secret that military scientists have not neglected bacteria and viruses in their search for the armament of destruction. It requires little exercise of the imagination to conjure up the uses to which bacteriology might be put as an instrument of national purpose.

While it is true that many weapons of chemical and bacteriological warfare have been available and, to our knowledge, not used since 1918, it is also true that a ruthless enemy, outstripped in one arms race may secretly be winning in another. Since Hiroshima and Nagasaki we have prepared to sustain a nuclear attack on non-military population. We have been educated for radiologic emergency, and our civilian defense is oriented in that direction. But chemical and bacteriologic emergency is equally imminent, and if it comes, doctors, as well as other medical and public health personnel, will of necessity lead the effort to cope with it.

If civilian defense is to be complete, it must be a defense against chemical and bacteriological warfare as well as radiological attack. Doctors everywhere must accept this fact and urge that the Nation be informed of the danger. We must insist that a health defense as adequate as possible be prepared, and we must equip ourselves for action on that damned day, when and if the attack occurs.

Let our purpose not be to augment the arms expenditure already consuming our resources, or to promote the dread apprehension of a confrontation of our Nation's enemies. But let us face up to the reality of the variety and diabolic ruthlessness of modern warfare in all its forms.—D. N. G.

A Cause For All

AS THE Christmas season approaches, worthy causes by the hundred are brought to our attention. Many of them merit consideration by their humanitarian or religious appeal, and many solicit through the special interests or enthusiasms we may entertain. But few fund-raising activities combine service to humanity and devotion to our professional interest so intimately as does the American Medical Association's Education and Research Foundation.

The Education and Research Foundation resulted when the AMA Education Foundation was merged with the AMA Research Foundation last January. Thus, the aims of providing financial assistance to medical schools and of financing scientific and medical research were integrated in a single foundation.

In Wisconsin the Education and Research Foundation provides funds for both the University of Wisconsin medical school and that of Marquette University. By contributing to the AMA-ERF, Wisconsin doctors can, in a very direct manner, return to their Alma Mater some of the prosperity they enjoy, made possible by the medical education given them through the largesse of others. At the same time we can subscribe to the betterment of human kind by participating in the financial support of important research.

The Wisconsin Committee of the AMA-ERF was until recently headed by Dr. Albion Heidner, past president of the State Medical Society and long time councilor. After his death, Dr. Porter B. Blanchard, of Cedarburg, accepted chairmanship of the Wisconsin committee. If a final persuasion were necessary to elicit a contribution to the ERF, it might well be that a donation will serve the dual purpose of honoring the memory of Doctor Heidner and encouraging Doctor Blanchard in his new undertaking, by confirming the faith of both in the public spirited generosity of their colleagues.

Please remember the AMA-ERF in your Holiday charity.—D. N. G.

COMMENTS FROM THE PRESS

Business Does Care

"Big business" does have a heart—a "big" heart. That is demonstrated from time to time and will be shown again on Sunday at Reedsville, Wis., when a modern clinic will be dedicated under the auspices of the American Medical Association. Where business is taking a part is in the cooperation and co-sponsorship by the Sears-Roebuck Foundation through its medical assistance program.

The medical-dental center in the Manitowoc County community has cost more than $55,000 and will serve an area population estimated at 5,000 people. Built by Reedsville Medical Center, Inc., a not-for-profit corporation of Reedsville citizens, the clinic was erected from funds raised from more than 800 area residents.

Construction of the Reedsville clinic, the first medical-dental unit in Wisconsin to be erected under the AMA-Foundation program, was undertaken as an incentive for doctors to establish their practices in the community. Reedsville had been without the services of a physician for five years. Arcadia, Chetek, Fox Lake, and Loyal are the other Wisconsin communities in which AMA-Sears-Roebuck Foundation clinics are located. A sixth clinic is under construction in Athens.

Purpose of the foundation representing "big business" is to assist such smaller communities throughout the United States to secure the services of doctors. Representatives of communities who feel their areas need the services of a doctor contact the Sears-Roebuck Foundation either directly or through the national, state, or local medical society. A survey of the community follows. If it shows the area can support a doctor, the first step is the construction of a modern facility.

The Foundation provides assistance in helping the community form a not-for-profit corporation to conduct a medical building fund-raising drive. Advice is given on how to conduct the drive itself. The building usually is financed through stock sold by the corporation.

Complete plans for the building are provided by the Foundation at no charge to the community.

Assistance is given also in securing a doctor to occupy the building. Help is given the doctor in the purchase of equipment and in organizing the business side of the practice.

Since the program's inception on Jan. 7, 1958, 63 communities in the United States have been assisted. Perhaps there are some in the Winnebagoland area that could be helped.—Reprinted from the *Oshkosh Northwestern*, Nov. 8, 1962.

The Medicare Myth . . .

The Medicare bill was fairly defeated by the 87th Congress, with a goodly percentage of members of both parties contributing to its demise. Nevertheless, the verbal battle goes on over its pros and cons during the current election campaign.

To place the need for Medicare in proper perspective, Americans should know the answers to two important questions. The first is this: What percentage of over-65 families owe debts to physicians, dentists and hospitals? The second: "What percentage of under-65 families had such debts?"

Can you answer these questions? Take a guess.

A survey conducted in 1961 by the University of Michigan Survey Research Center provided some reliable statistics. About 10 per cent of the under-65 families had physician, dentist and hospital debts, but only 4 per cent of the over-65 families owed such debts!

These statistics support the "shotgun technique" criticism which has fairly been leveled at the Medicare under Social Security approach. The vast majority of Americans would be included under the program, yet a rather small percentage really has a need. Literally hundreds of thousands who are wealthy would be provided Social Security Medicare funds, yet those retired who do not qualify for Social Security would be given no assistance.

Should 96 per cent of the over-65 families be included in a vast bureaucratic program because 4 per cent need financial assistance? This is what is meant by the "shotgun approach" to a problem which required rifle-like accuracy.

Thus, when you hear some politician claiming that his opponent is against good health for our older folks simply because he is against one specific legislative proposal, don't you believe it. The candidate may be against the "shotgun approach" but still favor another program, such as Kerr-Mills, for example, which meets a need without providing "shotgun" coverage.—Reprinted from the *Wausau Record-Herald*, Oct. 18, 1962.

Medical Care Dollar

Last year we Americans spent $20.8 billion for medical care—6.4% more than in 1960. But this figure needs a bit of interpretation if its significance is to be understood. The American Medical Association *News* provides it: "The cost of medical care, in relation to other consumer prices, went up less than 2% in 1961, but spending for medical care went up 6.4%. Obviously, there is a difference."

The difference lies in the fact that the public is demanding more medical services, and is willing to spend more to get them. "At the same time," says the *News*, "improved procedures and widening knowledge are giving the public more for its medical dollar than it ever got before."

A few more statistics are important here, in the light of the continuing controversy over the cost of medical care and, particularly, doctors' charges. The doctors' share of each medical care dollar has held steadily at 25 cents since 1955. In many prior years it was substantially more—28 cents in 1950, 30 cents in 1940, and about 33 cents in 1929. The hospitals' share of the medical care dollar has shown the biggest increase and that is attributable to expanded services and soaring operating costs.

These are facts—and they are hardly of a sort that could cause a reasonable person to rise in anger. The medical care dollar, today, produces an ultimate in return.—Reprinted from the *Beloit Daily News*, Nov. 5, 1962.

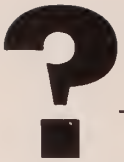
MANAGEMENT OF MEDICAL EMERGENCIES

Management of medical emergencies is the subject of a new book by Veterans Administration doctors. Designed to keep pace with advances in medicine and to provide a ready reference source for physicians, the volume is published by W. B. Saunders Company as a VA Hospitals Number (March 1962) of The Medical Clinics of North America.

The first chapter concerns identifying the medical emergency and the responsibilities of the physician. The other 23 chapters deal with emergencies ranging from heart attack to burns, psychiatric conditions, transfusion reactions, and poisoning.

Guest editors for the book are Dr. Benjamin B. Wells, the VA assistant chief medical director for research and education; Dr. Marc J. Musser, director of the VA research service, and Dr. Robert I. McClaughry, director of the VA medical education service.

The authors include outstanding physicians from 16 VA hospitals, the VA area medical office in Boston, and the VA Central Office in Washington, D. C.



How Much Social Security Can We Afford?

Address presented to the members of Neenah–Menasha Chamber of Commerce Twenty-second Annual Banquet May 15, 1962

By S. L. HORMAN, *Vice-President*

TIME INSURANCE COMPANY
Milwaukee, Wisconsin

IN THE LIFE of a nation there are times when it behooves its people to pause and consider how far it has drifted from its basic social and economic concepts!

This nation has arrived at such a time. The continuous assaults upon the very foundation of our form of government in recent years could well be a process of erosion that may destroy this last citadel of freedom!

Our system of free and competitive enterprise is today facing its greatest challenge—the challenge of whether we want to remain free and independent —proud of our heritage of initiative, thrift and self-reliance, or whether we want to become wards of the state!

My remarks today will cover but one significant phase of how we are legislating ourselves out of our birthright of personal freedom—not overlooking the re-vamping of the Supreme Court, the subserviency of local units of government to Federal rule, the lack of fiscal responsibility in curbing the national debt, and other important considerations. These are all significant, but more insidious is our continuing to seek something for nothing—at the cost of the other fellow!

We have succumbed to the appeal of politicians who have devised a "need" concept in our society. The inept business man, the inefficient farmer, the overaged, the lackadaisical workman—all are appealed to for votes, whether the "need" actually exists, and regardless of whether they deserve or want to deserve the better things in life. The philosophy is that those who are willing to produce must share with those who desire only to be consumers—a decadent philosophy that can end only in a socialistic state!

Our greatest American heritage has been the freedom we enjoy as citizens, and the privilege of providing for our material destinies through initiative and self-reliance, by methods that preserve the dignity of the individual. Our stand has normally been that there can be no real security or human dignity when freedom and opportunity become shackled by a paternalistic government that stresses subserviency to the state. These tenets are contemporaneous with the traditions and sustaining principles upon which this great country has flourished and prospered. We are fast getting away from that basic concept.

Subordinate only to the desire for freedom has been our desire for a higher standard of living and individual security. Instead of following through on our own, however, it seems we have been looking for an easier out by accepting the ideology of depending on governmental forces to take over our responsibilities, in spite of the fact that we have for three decades been enjoying social and economic progress unparalleled in the history of mankind. We have been overlooking the principle that the government is supposed to perform only those functions that its citizens are unable to do for themselves.

Normally, when we consider possible threats to our freedom and privileges, we think of outside forces—communism, socialism, or the physical invasion of our country by some other nation. However, it is my belief that the greatest threat to our American way of life right at this moment is the result of our own actions—not by any special design or intent, but the inordinate result of our deceiving ourselves.

We seem to be abandoning the principle of personal freedom, exchanging it for some form of subsidy from a government operating under a tax burden that already approaches the limit any economy can bear. We seek government aid for practically every conceivable project, most of which could be better performed at the community or state level—road building, expressways, parks, slum clearance, schools, school lunches, care for the infirm and indigent, and now, it is suggested that we add another tax burden by providing medical care for beneficiaries under Social Security (OASDI), in addition to retirement and disability benefits. This is a cause for serious contemplation, not because of a lack of concern for proper medical care for the overaged, but because of the method of providing it.

Let's review the history of the Social Security Act! Just twenty-four years ago, our Social Security Act became operative—in principle, a worthy

and humanitarian piece of legislation. The Act originally provided a basic floor for retirement benefits for retired workers age 65 or older, with the first payments to be made in 1942. But in 1939, Congress began changing the program, moving up the first payments to 1940 and providing benefits to survivors and dependents of retired or deceased workers.

Further major alterations were voted successively in 1950, 1952, 1954, 1956 and 1958–60—all election years for members of the House of Representatives and one-third of the members of Senate. During this period, without any specific increase in contributions, benefits have been increased, eligibility for benefits have been decreased, and benefits have been added for total disability, first for individuals over 50 years of age, and then in 1960 the age limit was removed. In 1961 the monthly minimum was increased, eligibility age lowered and benefits in all categories increased—all effective August 1, 1961, but without tax increase until 1962! It appears, unfortunately, that our Social Security Act has become a political football, and unless the American people become aware of its implications and where it is headed, it could jeopardize the security of millions of individuals depending upon it for their future retirement. It appears that many politicians are more actually concerned with manipulating those 16 million votes of the overaged, as a political expediency for themselves, rather than a genuine concern for the point at issue.

The real issues to consider in the Kennedy (King–Anderson) proposal to provide compulsory medical care for the aged are:

1. The government should perform only those functions for its citizens that they cannot perform for themselves.
2. Any welfare program should be on a *needs* basis.
3. Compulsory programs that give the citizen no alternative are but the keystone to further disenfranchisement of our personal liberties, and a forerunner to totalitarianism or socialism.
4. It has never been established that our senior citizens are suffering from lack of medical care.
5. The proposal makes no mention of covering some 4 million overage people who are not under Social Security.
6. The program is only a door opener, because the plan will cover less than 25% of medical expenditures of persons 65 or over, and still it would cost a conservative estimate of 2 billion dollars the first year.
7. Right at the outset Social Security taxes would be increased $25.50 for each employee, with a similar matching fund from his employer—in addition to the $6.00 each already added to the tax for this year, and other calculated increases already contemplated. Self-employed persons would similarly be taxed another $35.00 to $40.00.
8. Proponents of the program are misleading the American people by deliberately falsifying the need for such a program, both in estimating annual income of older people, and the number of persons who lack adequate medical care. A good illustration is the remark made by Senator Proxmire when speaking in Milwaukee on May 3, 1962—"There are hundreds of thousands of elderly people dying in America every year because of lack of medical care." Further, the proponents of the plan make no reference to individual savings, insurance, property holdings and other material wealth of the individual. The approach is that whatever has been accumulated for their old age and retirement should be kept intact, presumably to be left to some beneficiary, rather than to be spent for the purpose for which it was intended.
9. The big issue, of course, is whether present and future wage earners and employers should be compelled to pick up the tab for medical expenses for millions of elderly people who are able to pay their own way. This is the real issue.

In 1960 the Kerr–Mills Amendment was enacted. This provided for medical care on a *needs* basis for all senior citizens—not just those under Social Security. This legislation provided federal funds on a matching grant basis with states which enacted legislation to qualify for the program. It offers broader coverage for those who need it, and the total cost is estimated to be one-fourth the cost of the King–Anderson proposal.

Thirty-eight states have enacted legislation to qualify under the Kerr–Mills law. This program should be given a fair trial.

The important features of the law, however, are:

1. It not only takes care of those under Social Security, but it includes the 4 million citizens who are not.
2. The plan is not compulsory.
3. It operates on a *needs* basis.
4. It is administered at the local level, rather than by federal bureaucracy.
5. It does not ask present and future wage earners and employers to sacrifice their future income by paying medical bills today for many people who are able and willing to pay their own way.

Under present commitments, without additional benefits, the Social Security Administration estimates that by 1968 the tax will be 4 5/8% each for employers and employees, and 6.9% for the self-employed—call it 9% and 7%.

Approximately 80% of those under Social Security have their own voluntary health plans. Many more could have.

There were 13,700,000 people receiving monthly Social Security checks in March, 1960. At this time those beneficiaries had earned the equivalent of

$4.00 for each $100.00 a month they were and are receiving in benefits. By April, 1961, the number of beneficiaries had increased to 15,400,000.

Now the point we should consider is who is paying the unfunded $96.00 a month for each $100.00 being paid! The answer is simple—present and future wage earners!

In Wisconsin we have 395,000 citizens 65 or over. Where need exists, it is given. There are 400,000 youngsters under age 5, and where need exists, a remedy is devised. There is no person suffering from lack of medical care, and for those people who do need it, care can be provided on a local basis.

In summation, I believe these are facts worthy of consideration:

1. There are so many proposals of different activities for the government to take over from individuals and states that people are completely confused.
2. There is every reason to believe that within the next decade we shall be contributing 20% of earned income to support Social Security, even without further give-away amendments.
3. The rate of increased taxation, the growing number of subsidies, and controls, the continued expansion of government-owned businesses, and the unbelievable number of individuals receiving checks from the Federal Treasury are at the critical point of tipping our American scales toward the sterile abyss of socialism.
4. We cannot compare our social and economic program with the decadent philosophy of European countries where *compulsory* medicine resulted in totalitarianism, socialism, communism or complete chaos.

I further believe these are conclusions and questions we must face:

1. Do we have the moral right to penalize the generation of wage earners now coming up to sacrifice that amount to provide our security, and
2. Is it not our obligation to protect the birthright and privilege we have enjoyed for those who are to follow after us? Why shackle them with a taxload and abnegation of the opportunities of free enterprise because of our apathy in accepting a decadent philosophy that brought nothing but chaos in Europe where it was first practiced?

There is nothing more discouraging than a hope or a promise that is unfulfilled. The present generation depends upon us for the perpetuation of joys and privileges we enjoy today. It is up to us to justify that faith by not giving away their rightful heritage because of our own selfishness.

The situation is not hopeless—all we have to do is get back to basic fundamentals—earn the right to enjoy the freedom and fruits of our system of free enterprise and not let it go by default by deceiving ourselves into thinking we can get something for nothing. Let us not run the risk of having some future generation refer to us by saying—"*They thought they could have just a little socialism.*"

COMMENTS FROM THE PRESS

Medicine's Attitude

The medical profession has been subjected to a considerable verbal beating in late years—much of it, obviously, based on political motivations or plain ignorance.

So a direct and simple statement of the profession's attitude and purpose—an attitude and purpose shared by the great majority of this country's doctors and other medical personnel—is in order. Dr. George M. Fister, now president of the American Medical Association, provides it: "We will not compromise with those who regard medical care problems as simply playthings in the game of politics . . . gimmicks to attract the votes of the gullible. But we will cooperate, to our very utmost, with government officials, legislators and all Americans who are sincerely interested in finding sound, practical solutions to such problems—solutions which include both a respect for medical standards and a respect for the taxpayers."

This policy applies to the medical problems of elderly people, which have, unfortunately, become a bitter political issue, as well as to the medical problems of all other age groups. The medical profession has been an effective force in helping to expand voluntary health insurance at a reasonable cost. It has been solidly behind the Kerr–Mills bill, passed two years ago, which offers extensive medical services under a federal-state program to those who cannot pay for them out of their own pockets. And it is a rare doctor who does not donate time and hard-won knowledge, without cost, to treating the indigent.

Medicine's fight is against political domination—against a system in which a bureaucracy would write and apply the rules. If it wins that fight, the primary beneficiaries will not be the doctors, but the sick.—Reprinted from the *Owen Enterprise*, Nov. 8, 1962.

THE MEDICAL FORUM

SMS Sues Commissioner in WPS Insurance Dispute

Accusing Insurance Commissioner Charles Manson of usurping the powers of the Legislature, the State Medical Society filed suit in Dane county circuit court November 20 challenging Manson's right to force the Society's health insurance division, Wisconsin Physicians Service, to pay claims of podiatrists, also known as chiropodists.

"Our disagreement with Commissioner Manson involves two points," said Dr. E. M. *Dessloch*, Prairie du Chien, chairman of the Society's Commission on Medical Care Plans. "First, we challenge his authority to issue the ruling at all. Second, we deny his claim that a podiatrist is a physician and surgeon for a limited portion of the body, namely, the foot."

The issues arose last July 30, when Manson ruled that sickness insurers must include podiatrists under the definition of "physician and surgeon" or exclude benefits for treatment of the feet.

"A podiatrist is a technician, but there is no patient–physician privilege between him and the person he treats," Doctor Dessloch said. "He cannot sign death certificates or other vital statistical records; he cannot use narcotic drugs; he is not exempt from quarantine laws, and in many other ways he is under restrictions as to his activities. To argue that these men are physicians and surgeons seems ridiculous to us."

"Furthermore, we don't think Commissioner Manson has any authority to tell insuring organizations such as ours what must be in the benefit provisions of their contracts," declared Doctor Dessloch. "This is a matter of contract between the purchaser and the seller. We still think that the purchaser has a right to determine what he wants, and if he wants the services of a podiatrist included as a benefit, we will provide it at additional cost."

"We think that insuring agencies also have a right to decide what benefits they will provide," Doctor Dessloch stated. "Here's where we think Commissioner Manson is usurping authority which has not been delegated to him by the Wisconsin Legislature."

Venereal Disease Incidence, Commitment Laws Discussed by Commission on State Departments

Incidence and source of venereal diseases in Wisconsin, together with possible informational programs for the medical profession, were discussed by the Commission on State Departments of the State Medical Society at Society headquarters, November 4.

Acting under a request of the House of Delegates, the Commission invited Dr. A. L. Van Duser, Madison, of the State Board of Health, to review the history of incidence of venereal disease in the state.

Doctor Van Duser stated that improvements are possible in: (1) reporting of gonorrhea, (2) more complete investigation of sources and contacts, perhaps best accomplished by cooperative effort of the physician and public health worker, and (3) maintenance of serology programs in the physician's office and hospital with thought to a routine serology as a general admission procedure in hospitals under rules determined by the medical staff.

The State Board of Health is developing a booklet on syphilis which will be available in midsummer 1963.

The Commission decided that the procedure or guidelines for reporting of venereal diseases be published in the *Wisconsin Medical Journal* and that the availability of the new booklet be publicized in the Journal.

The Commission accepted the recommendation of its Division on Nervous and Mental Diseases that a special study committee on commitment laws be appointed.

In other actions, the Commission:

1. Stated that the film, "Youth Physical Fitness—A Report to the Nation," is worthwhile as a mechanism to stimulate interest in physical fitness, but its usefulness would be enhanced by comments prior to the showing by an individual with a physical education background. He could call attention to sequences in the film which do not agree with current concepts in the field.
2. Recommended plasticizing of 1,500 revised First Aid charts for posting in public locations such as parks, swimming beaches, and recreation areas.
3. Reaffirmed its stand in favor of implied consent legislation, subject to legal clarification of the constitutionality of such laws.

Health Insurance Benefits

Health insurance benefit payments by insurance companies in 1962 are running 12 per cent ahead of last year, the Health Insurance Institute reports. In the first nine months of 1962 insurance companies distributed an estimated $2,917,000,000, or an average of nearly $10.7 million a day, in benefits to persons covered by health insurance policies.

Public Relations Program in Douglas County Stresses Cost of Medical and Hospital Care

The Douglas County Medical Society took the problems of medical economics to the public when it successfully staged its second annual public relations meeting for the community in October. Press, radio and TV representatives and community leaders in schools, churches, government, organized labor and industry were guests of the Society at a dinner meeting held in the Superior State College Student Union at Superior.

Purpose of the meeting, as explained by Dr. I. H. *Lavine*, president of the Douglas County Medical Society, was "to acquaint responsible representatives of all lines of endeavor, and through them the general public, with the fact that the rising costs of medical care reflect the greatly broadened program of hospital care particularly, which the public has come to expect because of hospital insurance programs of health and accident coverage."

Principal speakers for the event were Dr. Enzo **Krahl**, Superior, who discussed "The Cost of Medical Care," and Dr. James P. **McGinnis**, Superior, who talked on "Medical Care for the Aged and Its Political Implications." A question and answer period followed.

The attendance of 127 community leaders, including 19 physicians, was the result of extensive planning. The guest list was prepared with the help of the local Chamber of Commerce. When the response to 145 printed invitations was discouraging, follow-up phone calls were made and resulted in an attendance which exceeded expectations. All guests were given name badges and the physicians met many members of the community for the first time.

The success of the Society's first public relations program which was under the direction of Dr. John G. **Heisel**, formerly of Superior, in 1961 prompted the Society to make the event an annual one. Doctor Krahl and Doctor McGinnis were in charge of arrangements for this year's dinner with Dr. James W. **McGill** acting as master of ceremonies.

JACK HIGGINS, A JUNIOR at the University of Indiana, worked as a preceptee with Drs. Robert W. Adams (center) and Joseph E. Powell (right) in the Chetek Medical Clinic last summer. The preceptor program has been set up by the Sears–Roebuck Foundation in conjunction with the Student American Medical Association to enable junior and senior medical students to gain practical experience in the practice of medicine in a small community.

SAMA-Sears Foundation Preceptor Program Is Given Pilot Study

A pilot study of a preceptor program set up by the Sears-Roebuck Foundation in conjunction with the Student American Medical Association is near completion, and two of the first eight SAMA-Sears $500 scholarship recipients are Thomas Y. **Fung**, a University of Wisconsin medical student, and Jack **Higgins**, a University of Indiana student who took his preceptorship in a Wisconsin town.

Higgins, who is a junior medical student, spent the summer at Chetek, a small Wisconsin resort town with a population of approximately 1,900, where he worked with Drs. Joseph E. **Powell** and Robert W. **Adams** in the Chetek Medical Clinic. In addition to gaining practical experience, he had an opportunity to learn the mechanics and economics of running a medical practice.

Fung, whose residence is in Madison, spent his summer in Champlain, New York, a vacationland village of about 800 persons. Working with Dr. Richard **Schultheis**, the only physician in the community, he learned the various aspects of his broad practice first through observation and later through actual participation in seeing patients and carrying out diagnostic and treatment procedures under Doctor Schultheis' supervision.

Both students recommended in their reports that the preceptor program be continued.

"It gives the medical student a chance to see a small community where he would not have thought of going into practice because of preconceptions, bias, or foggy ideas," said Fung.

Medical Supplies Needed at Peruvian Mission

Father Daniel **McGrew**, a Racine native whose parents still live in Racine, is in need of physician's medical supplies and samples for his mission in Peru where he provides aid to some 40,000 poverty stricken Indians. Medical supplies can be sent to him at the following address: Father Daniel McGrew, Yunguyo, Peru, % Maryknoll Fathers, Maryknoll, N. Y.

Medical Society Wins Suit Against Blue Cross

The State Medical Society of Wisconsin won its claim to recover $28,330.52 from Associated Hospital Service, Inc. (Blue Cross) in Judge Richard Bardwell's circuit court in Madison early in November.

Wisconsin Physicians Service, the Society's insurance division, alleged that Blue Cross illegally withheld the money in 1958 when the State Medical Society and Blue Cross terminated their contract under which Blue Cross did the selling, billing and recording of WPS policies.

The amount of the claim represented the service fee for nearly 62,000 large group contracts billed by WPS in January 1958, and for 51,190 small group contracts billed in February 1958.

According to WPS, Blue Cross performed its last duties in December 1957. However, many groups were a month or more late with their payments, and Blue Cross continued to deduct a service fee of .2269 cents per contract for all policies serviced the month after the contract should have been terminated.

Judge Bardwell agreed with the WPS contention that there had been an adequate agreement with Blue Cross to prevent confusion over late payments, and that delays had been customarily dealt with by the firm. He also noted that Blue Cross was required to do no promotional or educational work to enroll customers during the six months after it had been notified by WPS that the contract would be terminated, but did accept its standard payment of .2269 cents for 22,000 new subscribers enrolled during that period.

Commission on State Departments Appointments

The Commission on State Departments of the State Medical Society, meeting at Society headquarters in Madison on November 4, made the following appointments of Division members:

DIVISION ON AGING—Drs. Craig Larson, Milwaukee, reappointed, and Roger C. Cantwell, Shawano, appointed, for terms ending in 1965.

DIVISION ON CHEST DISEASES—Drs. Warren K. Simmons, Rhinelander, reappointed; John H. Wishart, Eau Claire, and George C. Owen, Milwaukee, appointed, for terms ending in 1965.

DIVISION ON HANDICAPPED CHILDREN—Drs. George C. Handy, Wisconsin Rapids, reappointed, and J. E. Miller, Madison, appointed, for terms ending in 1965.

DIVISION ON MATERNAL AND CHILD WELFARE—Drs. E. A. Birge, Milwaukee, K. J. Winters, Wauwatosa, and Stewart L. Griggs, Green Bay, reappointed for terms ending in 1965.

DIVISION ON NERVOUS AND MENTAL DISEASES—Drs. Francis M. Forster, Madison, reappointed, Raymond Headlee, Milwaukee, and Otto A. Dittmer, Ripon, appointed, for terms ending in 1965; and Edward E. Houfek, Sheboygan, for a term ending in 1964.

DIVISION ON PUBLIC ASSISTANCE—Drs. C. M. Carney, Beloit, and E. W. Schacht, Racine, reappointed, for terms ending in 1965.

DIVISION ON REHABILITATION—Drs. R. L. Gilbert, La Crosse, and Harry D. Bouman, Madison, reappointed for terms ending in 1965.

DIVISION ON SAFE TRANSPORTATION—Drs. Richard C. Wixson, Madison, reappointed; Frederick Bunkfeldt, Jr., Milwaukee, and Walter F. Smejkal, Manitowoc, appointed, for terms ending in 1965.

DIVISION ON SCHOOL HEALTH—Drs. Frances A. Cline, Rhinelander, and William T. Brodhead, Madison, appointed for terms ending in 1965.

DIVISION ON VISUAL AND HEARING DEFECTS—Drs. C. G. Reznichek, Madison, S. B. Russell, Eau Claire, and George Nadeau, Green Bay, reappointed, for terms ending in 1965.

State Board of Health Advisory Committee Appointments Made

A Madison pharmacist and a Racine dentist have been appointed to three-year terms on two State Board of Health advisory committees.

They are: Richard G. Henry, chief pharmacist at the Madison General hospital, who was named a member of the advisory hospital council, and R. L. Gorsky, D.D.S., Racine, who was appointed to the dental advisory committee.

Reappointed to three-year terms on the advisory hospital council are: Sister M. Regula, St. Francis hospital, La Crosse; Mrs. Otto Falk, Oconomowoc; H. A. Sincock, M.D., Superior, and W. R. Plater, D.D.S., Madison.

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November Sees "M" Days at SMS Headquarters

THE AUXILIARY TO THE DANE COUNTY MEDICAL SOCIETY was the first group to meet in the President's Room of the new west wing of the Society's headquarters in Madison. The large room will be available for medical and health meetings.

Moving and adjustment were the orders of the day during much of November as the total staff of the State Medical Society was brought together under one roof upon completion of the new west wing of the Society's headquarters.

The accounting department, stenographic and mail services, library, machine services department, and stock rooms of the State Medical Society and the claims department of Wisconsin Physicians Service are located in the new wing.

First group to utilize the President's Room, the large lecture room on the second floor of the new wing, was the Woman's Auxiliary to the Dane County Medical Society on November 12. The room is furnished with long, slim tables and cushioned chairs in shades of brown, rust, yellow, and green. It can be divided into smaller meeting rooms, and is adjoined by a small service kitchen. It will be available for meetings of medical organizations and health groups.

Other areas of the main building have been rearranged for more efficient utilization of space and better coordination of services.

Survey Stresses Physician's Personal Attitude

Next to his qualifications and skill, patients regard the physician's personal interest in his clients as their major concern, it was pointed up in a study by the University of Wisconsin Survey Research Laboratory. The preliminary report was supported by the Health Information Foundation of New York and the University of Wisconsin Graduate Research Committee.

Prof. David Mechanic of the University sociology department, faculty participant in the survey, explained:

"Our findings show 92 per cent of the mothers agreeing with the statement, 'the most important thing about a doctor is that he be a good diagnostician.' But 75 per cent disagreed with the statement, 'a doctor's personal manner isn't important as long as he is a skilled doctor.'

"The importance of the personal side of the doctor-patient relationship is further reflected in the belief held by 66 per cent of the mothers that the doctor's job 'has a spiritual side to it,' also by the belief of 81 per cent that 'it is essential that a doctor be a friend and advisor,' and further, the belief of 61 per cent that 'doctors should get to know their patients on a personal, friendly basis.'"

The survey showed that 90 per cent of those interviewed have a family doctor or clinic they use regularly. Major reasons for choosing their particular physician were: (1) recommendation of friends, neighbors, and others—34 per cent; (2) recommendation of a doctor or a person working in the health field—20 per cent; and (3) convenience and accessibility of a doctor's office—16 per cent.

One of every two mothers queried said willingness to make house calls represented an important factor in selecting a physician.

"The survey shows that physicians must deal with patients as persons whose attitudes and values play a part in the treatment process," Professor Mechanic said. "It is equally true that persons also often expect miracles of physicians and sometimes have unrealistic expectations of them. The quality of the relationship depends on both parties showing consideration and respect. There probably is room for improvement on both sides."

WPS to Cover Prescription Drug Bills

Prescription drug bills will be covered in a new health insurance policy to be offered by Wisconsin Physicians Service, the Blue Shield plan of the State Medical Society.

"As far as we know, this is the first policy of its kind in the country," said Dr. E. M. Dessloch, Prairie du Chien, chairman of the Society's Commission on Medical Care Plans.

Until now, drugs used outside the hospital have been covered only through WPS major illness policies.

The new WPS plan was proposed by Dr. E. J. Nordby, Madison, member of the Commission on Medical Care Plans. Enrollment will be through groups or individuals on a community basis, regardless of whether they are now WPS subscribers. The plan insures free choice of pharmacists.

"Development of the new contract continues efforts of WPS to assure protection that keeps pace with modern medical practice," said Doctor Dessloch. Drugs now account for nearly 20 per cent of total health care expenditures.

The new policy is expected to have a deductible feature. Payment for patent medicine and proprietary drugs would not be included. Estimated cost of the coverage will be about $8 per person per year.

Named to Committee on Nursing Homes

A Madison physician and a Neillsville hospital official have been named to the State Board of Health's advisory committee on nursing homes.

They are Dr. G. G. Stebbins, Madison, and John R. Temte, administrator of the Neillsville Memorial Hospital, both of whom were appointed to three-year terms expiring Oct. 23, 1965.

They succeed Dr. A. M. Hutter, Fond du Lac, and Warren Von Ehren, executive director of the Wisconsin Hospital Association, both of whose terms expired last month.

SMS Representatives to Staff Two Regions

Mr. Donald Idzik, Fond du Lac, and Mr. Glenn Waldschmidt, Wausau, have been appointed regional representatives for the State Medical Society.

GLENN WALDSCHMIDT

DONALD IDZIK

Mr. Idzik, who is staffing the northeastern Wisconsin region, had been a Wisconsin Physicians Service field representative since 1957 and recently had been servicing the Fond du Lac area.

Mr. Waldschmidt, who is staffing the north central Wisconsin region, is home-based at Wausau. He formerly was a WPS district manager of the Eau Claire office, and most recently was employed with the Aid Association for Lutherans.

Door-Kewaunee Group Offers Guidance in Career Days Programs

The Door–Kewaunee County Medical Society on December 3 participated in county-wide career days in Kewaunee county by speaking to high school students interested in the career of medicine.

Students from the four high schools in the county met with physicians in Kewaunee and Luxemburg. Sophomores and juniors attended sessions during the day and seniors and their parents were offered an evening conference in Kewaunee.

Presentations were also made by representatives of nursing, medical technology and physical therapy. These and medicine were the four most popular health careers determined by a poll of the students.

Arrangements for the guidance counseling sessions in medicine were made through Dr. Charles W. Stiehl, president of the Door–Kewaunee County Medical Society. Reference materials were provided by the State Medical Society and American Medical Association and included individual leaflets for each student as well as information on entrance requirements, cost of medical education, and loan and scholarship information.

LOAN AVAILABLE TO WOMAN RESIDENT

The American College of Obstetricians and Gynecologists has some funds available for a loan to a woman resident physician through its H.E.L.P. program. If you know of a woman resident who can use this financial assistance, please advise her to contact the College Administrative Office, 79 West Monroe Street, Chicago 3, Ill.

PROFESSIONAL BUSINESS SERVICE
207 N. Tenth Street
La Crosse, Wisconsin

Business Consultants to the Medical Profession.

Inquiries Invited

Plan Full Scale Medical Self-Help Training

Wisconsin physicians will be asked to play an increasingly important role during 1963 in the Medical Self-Help Training program which trains people to meet their own health needs in case of national emergency.

Future planning for the program will be undertaken at a meeting of the state advisory committee January 14 in Madison. Dr. John S. *Wier*, Fond du Lac, chairman of the State Medical Society's Committee on Disaster Medical Care, is a member.

The advisory committee will review the pilot program, conducted in the state during 1962, and map out plans for full scale instruction in 1963 and future years.

In the pilot program more than 1,000 Wisconsin residents were trained—ranking the state seventh in the nation. However, the major task remains to be accomplished—training one member in each family, an estimated 1,250,000 people in Wisconsin alone.

The pilot program was conducted with 80 instructional kits located in various parts of the state. A list of the kits presently in use in Wisconsin appears in this issue of the FORUM. It is anticipated that this number will be increased substantially for next year.

In addition, a Public Health Service representative has been assigned to Wisconsin as of December 3, 1962, to work in the area of emergency medical services and more specifically in implementing the Medical Self-Help program.

Medicine's role in the program is clearly outlined in the administrative guide:

"The key figure in the Medical Self-Help Training program is the practicing physician."

To assist the physician and to do the actual instruction in many instances, allied health personnel, teachers and others with instructional ability will be asked to take part.

However, it is the aim that each course—regardless of who serves as instructor—be under the supervision and guidance of a physician.

Lessons in the course, designed to be presented in eight two-hour sessions, are: Radioactive Fallout and Shelter; Hygiene Sanitation and Vermin Control; Water and Food; Shock; Bleeding and Bandaging; Artificial Respiration; Fractures and Splinting; Transportation of the Injured; Burns; Nursing Care of the Sick and Injured; Infant and Child Care; and Emergency Childbirth.

Museum Acquires "In-Mo-Ray" Machine, Quackery Device

An "In-Mo-Ray" machine, predecessor to the neurolinometer, has been recently acquired for the quackery display at the Museum of Medical Progress at Prairie du Chien. Its history has been checked with the American Medical Association which provided some background details on the device.

In 1927 the A.M.A. received a pamphlet put out by Therapeutic Apparatus, Inc., of New York City, describing "In-Mo-Ray Therapy (Pasque)" as the discovery of Ernest H. Pasque, "a widely known physicist and scientist." It was stated that "his work, 'The Electro-Chemical Factor in Neurology,'" was published by the Atomic Research Association of 502 Boydell Building, Detroit. Further description stated:

"The modality produced in this remarkable apparatus which we have named 'IN-MO-RAY,' i.e., Intra-Molecular-Ray, is a selective concentration of electromagnetic energies, which, when set in motion, disturb the magnetic fluxes, and set up electromagnetic induction, internal eddy-currents, ionization or ionolysis—in brief, mobilization of the atoms in the chemical molecule—all of which energize the electrical and chemical phenomena inherent in the cells throughout the living body and thus restores their functional activity."

A.M.A. files also contain a Dun & Bradstreet report, dated 1927, on the E.R.V. Corporation which stated that Dr. H. H. Farnham was formerly the president of the concern and added: "Sec.–Treas. Ernest Pasque is a son-in-law of Dr. Farnham and was formerly engaged in medical research, etc. Considered a scientist of more than ordinary ability."

AN "IN-MO-RAY" MACHINE, now in the possession of the Museum of Medical Progress at Prairie du Chien, was a combination of the Abrams fakery and the Wilshire 'I-on-a-co,' according to the American Medical Association.

The Department of Investigation of the American Medical Association, in answering inquiries on the subject in those days, stated:

"Ernest H. Pasque seems to have been one of the leading spirits in the exploitation of a so-called electronic radio-vibratory instrument. This apparently was a combination of the Abrams fakery and the Wilshire 'I-on-a-co.' Pasque is not a physician, according to our records."

WEST BEND CHANGES TB SKIN TESTING PROGRAM

On recommendation of the Washington County Medical Society and with the approval of the West Bend Board of Health, tuberculin testing of West Bend school children will be done as a part of the physical examination in the doctors' offices. Physical examinations are done on all children entering school, fourth grade pupils, all students entering high school and those starting their junior year.

The doctor will indicate on the physical examination form the results of the tuberculin test. Physical examination recommendations are returned to the health department and it is the official agency's responsibility for seeing that adequate protective measures are taken.

Commission Approves Oral Surgery Rider

The Commission on Medical Care Plans of the State Medical Society has approved an oral surgery rider to be attached to Wisconsin Physicians Service contracts and now awaits authorization from the State Insurance Department before offering it to the public.

The rider, in consideration of the payment of additional premium, would amend the WPS policy or contract to cover 16 specific procedures performed by a dentist. Six of the named procedures fall under the general category of fractures.

Urge Physicians to Meet with School Officials on Youth Health Programs

Dr. N. A. Hill, Madison, president of the State Medical Society, and Angus B. Rothwell, state superintendent of public instruction, have issued a joint communication to all presidents of county medical societies and Wisconsin school administrators urging local physicians to meet with school officials in their area during the 1962–63 school year to consider health and fitness programs and any problems which may exist.

A reply from Dr. H. C. Marsh, president of the Shawano County Medical Society, reports that his society has had "at least two meetings with the district superintendent of our local school district. The chief topic discussed was the examination of school children and especially the school teachers."

The Council of the State Medical Society and the Division on School Health of the Commission on State Departments have urged local medical societies to "adopt a program of liaison with local school officials and others concerned with the health of school-age children." It was suggested that physicians, because of their more formal organization at the local level, take the initiative in making contact to discuss procedures necessary in finding a solution to problems common to both.

LOCATION OF MEDICAL SELF-HELP KITS IN USE IN WISCONSIN

COUNTY	ORGANIZATION	CUSTODIAN
Ashland	Civil Defense	Clarence Day, Ashland
Brown	Civil Defense	Arthur E. Norgaard, Green Bay
	School of Voc. & Adult Education	K. W. Haubenschild, Green Bay
Buffalo	Civil Defense	Howard Mohnk, Cochrane
Clark	Home Agent	Judith Berget, Neillsville
Columbia	Civil Defense	Lester Clark, Wisconsin Dells
	Home Agent	Margaret Patchett, Portage
Crawford	Civil Defense	Jay H. Kettner, D.O., Gays Mills
Dane	Civil Defense	Richard Wilson, Madison
	School of Voc. & Adult Education	Howard Heigl, Madison
	High School	John R. Thorson, Verona
	U. of W. Medical School	Robert J. Samp, M.D., Madison
Dodge	Civil Defense	William Funcke, M.D., Beaver Dam
Door	Civil Defense	Leon Schram, Sturgeon Bay
	Home Agent	Phyllis Onsager, Sturgeon Bay
Douglas	Civil Defense	Harold E. Larson, Lake Nebagamon
Dunn	Home Agent	Shirley Young, Menomonie
Eau Claire	Civil Defense	Paul T. Boley, Eau Claire
Fond du Lac	Civil Defense	Harvey L. Hinkley, Sr., Fond du Lac
Grant	Civil Defense	Clair Boughton, Lancaster
	Home Agent	Nancy Burgy, Lancaster
Green	Civil Defense	Charles B. Marvin, Monroe
Jackson	Home Agent	Nyla Musser, Black River Falls
Jefferson	School of Voc. & Adult Education	A. C. Prabst, Fort Atkinson
	School of Voc. & Adult Education	Glenn Johnson, Watertown
Juneau	Home Agent	Noreen Cook, Mauston
	School of Voc. & Adult Education	Roy Simpson, New Lisbon
Kenosha	School of Voc. & Adult Education	E. I. Lehrmann, Kenosha
Kewaunee	Home Agent	Betty Rehfeld, Kewaunee
La Crosse	Civil Defense	John J. Satory, M.D., La Crosse
Langlade	Civil Defense	Peter P. Krosnicki, Antigo
Manitowoc	Civil Defense	Edward McConnell, Manitowoc
	School of Voc. & Adult Education	Conrad Mayer, Two Rivers
Marathon	Civil Defense	Chester Neese, Wausau
	Home Agent	Eileen Neidermeier, Wausau
	School of Voc. & Adult Education	L. H. Hoyt, Wausau
Marinette	Civil Defense	John Schuchart, Marinette
Milwaukee	Civil Defense (4)	Jose Lowry, Milwaukee
	School of Voc. & Adult Education	George Parkinson, Milwaukee
	School of Voc. & Adult Education	Gustav Hirsch, Cudahy
	Wisconsin Telephone Co.	Kenneth W. Keene, Milwaukee
Monroe	Home Agent	Janet Sperstad, Sparta
Oconto	Civil Defense	Corinne Blazek, R.N., Oconto
Outagamie	Civil Defense	Russell Hildebrand, Appleton
	School of Voc. & Adult Education	Dominic Bordini, Kaukauna
Ozaukee	Civil Defense	John F. Walsh, M.D., Port Washington
Polk*	Civil Defense	Fred B. Riegel, M.D., St. Croix Falls
Portage	Civil Defense	Frederick W. Reichardt, M.D., Stevens Point
Price	Home Agent	Hazel Crook, Phillips
Racine	Civil Defense	James Cook, M.D., Racine
	Home Agent	Dorothy Hodgekiss, Racine
	High School	Myrtle Pitznes, Burlington
Rock	Civil Defense	Herbert Snodgrass, M.D., Janesville
	Civil Defense	Rod Baptist, Beloit
	School of Voc. & Adult Education	Orvis Johnson, Janesville
	School of Voc. & Adult Education	R. A. Oster, Beloit
St. Croix	Civil Defense	James L. Craig, M.D., New Richmond
Sauk	Civil Defense	James Tibbitts, M.D., Reedsburg
Sheboygan	Civil Defense	George M. Adams, Sheboygan
	Home Agent	Barbara Jackson, Sheboygan
	School of Voc. & Adult Education	Jacob Spies, Sheboygan
Trempealeau	Civil Defense	Howard Mohnk, Cochrane (Buffalo Co.)
Vernon	Civil Defense	Gaylord Schroeder, Hillsboro
	Home Agent	Lillian Loken, Viroqua
Walworth	Home Agent	Priscilla Hargraves, Elkhorn
Washington	Civil Defense	Ray Storck, Slinger
	Home Agent	Jane Williamson, West Bend
Waukesha	Civil Defense	Ruth Church, M.D., Waukesha
	High School	Georgia Patterson, R.N., Brookfield Central
Waushara	Home Agent	Patricia Spielman, Wautoma
Winnebago	Civil Defense	George Oaks, Oshkosh
	School of Voc. & Adult Education	H. L. Sherman, Menasha
Wood	Civil Defense	Catherine Woodrich, R.N., Wisconsin Rapids
	Home Agent	Loretta Zastrow, Wisconsin Rapids
	School of Voc. & Adult Education	John Murphy, Marshfield
	School of Voc. & Adult Education	Eldon Everetts, Wisconsin Rapids

Football Injuries Booklet

A 14-page pamphlet on "Football Injuries" is now available free to team physicians who request it. The prevention, detection, and treatment of all common injuries as well as physical conditioning and heat exhaustion are discussed.

It is available from: Professional Services Department, Mead Johnson Laboratories, Evansville 21, Indiana.

WPS Century Plan Enrollment Rises Steadily

Current enrollment for the Wisconsin Physicians Service Century Plan, the State Medical Society's health insurance program for senior citizens, gained a total of 1,629 new subscribers during the month of October and for the first time took the total number of contracts over the 10,000 mark to 10,390.

Inquiries continue to come in to the State Medical Society headquarters at an unprecedented rate —approximately 2,500 last month, with 200 in two days. They have resulted primarily from a special Senior Citizen promotion in the *Saturday Evening Post* and daily newspapers tied in with the national Blue Shield Senior Citizen enrollment. Simultaneously local WPS agents are advertising in their individual areas, and calls they receive raise the inquiry tabulation even higher.

Several hundred inquiries also have been received during the last two months on Major Medical contracts, largely attributable to local advertising. Interest is high and is expected to continue throughout the special promotional period ending December 31, 1962.

CARE OF INJURED PROCEDURE OUTLINED BY SHEBOYGAN SOCIETY

The Sheboygan County Medical Society is suggesting to city police and firemen and sheriff's deputies a procedure to be followed in the transportation and subsequent care of injured persons. Based on the premise of free choice of physician and the right of the injured person to have the services of his family doctor in case of emergency, the society's suggested procedure is as follows:

1. The officer should inquire whether or not the injured person has a family physician. This doctor is to be notified and will care for the patient at the hospital or office as the severity of the case demands.

2. A patient without a family physician, or whose family physician cannot be reached, is to be removed to the hospital of his choice and the physician on emergency call is to be notified.

3. Unconscious patients or nonresident casualties without a choice of local doctors are to be removed to one of the hospitals and the doctor on emergency call is to be notified to care for the patient.

WPS Reserves Increase

During September, $70,044 was added to the reserves of Wisconsin Physicians Service as a result of a favorable balance of premiums received over claims paid, according to a financial statement recently issued.

With an increase of $222 in the market value of securities, the total added to reserves of the health insurance division of the State Medical Society during September was $70,266, bringing the total of reserves at the end of the month to $2,197,143.

Mark Your Calendar!

1963 SMS Meeting Dates

Jan. 12: Section Delegates and Officers (rescheduled)
Jan. 26: Commission on Medical Care Plans
Feb. 18–22: Wisconsin Work Week of Health
Feb. 23–24: Annual Council Meeting
Mar. 24: Second meeting of Sections, previously scheduled
Apr. 18–20: Health Fads and Fallacies
Apr. 20: Commission on Medical Care Plans
Apr. 22–May 3: Two-week period reserved for delegate caucuses
May 5: Council—Milwaukee
May 6–9: Annual Meeting
June 16–20: AMA—Atlantic City
June 29: Commission on Medical Care Plans
July 26–27: Council—La Crosse
Oct. 19: Commission on Medical Care Plans
Oct. 26–27: North Central Conference
Nov. 2: Council—Madison
Dec. 1–4: AMA—Portland

DR. R. L. TROUP (right), Green Bay, president of the Brown County Medical Society, introduced John T. O'Hair (left), Milwaukee, as guest speaker at a recent county meeting. Mr. O'Hair administers the State Medical Society's group disability insurance program for the Provident Life and Accident Insurance Company.

Glaucoma Clinic Held

The Brown County Medical Society, under the direction of Dr. Wilson J. Troup, Green Bay, sponsored a one-day free glaucoma screening clinic for all residents over 40 years of age on December 8 at the Green Bay City Hall. The Lions Club of Green Bay cooperated in making arrangements for the clinic.

Need for the public test was outlined to members of the Lions Club by Dr. John A. Ottum. The clinic was conducted by ophthalmologists and patients were referred to their own ophthalmologist.

Wins Farm Bureau Award

Kenneth G. Reeb, a fourth year medical student at the University of Wisconsin who is the father of four children, is the winner of the $483 Rasey scholarship award for 1962.

The award, which represents the proceeds from stock set aside in the wills of the late Edwin L. and M. Etta Rasey, Beloit, was presented to Mr. Reeb at the Farm Bureau's farm family dinner held in Madison in November.

Minutes of Council Meeting

Land O'Lakes, Wisconsin, July 27–28, 1962

1. Call to Order and Roll Call

The Council was called to order by Chairman Fox at 2:15 p. m. on Friday, July 27, 1962, at King's Gateway, Land O'Lakes.

All councilors were present except Doctors Dessloch, Blanchard, Ekblad, and W. J. Houghton. Officers and others present were President Hill, President-elect Egan, Speaker Callan, Vice-speaker Carey; Doctors Bernhart and Galasinski, AMA delegates; Doctor Collentine, alternate; Messrs. Crownhart, Thayer, Ragatz, Reynolds, Murphy, Gill, White, Tiffany; Mrs. Anderson and Miss Pyre. Present Saturday were Drs. R. G. Zach and R. W. Farnsworth, and Mr. Aubrey Gates, AMA Director of Field Service.

2. Approval of Minutes

On motion of Doctors Willson–Schulz, carried, minutes of the May 6, 1962, meeting were approved.

3. Oath of Office

Chairman Fox administered the oath of office to the councilors elected by the House of Delegates in May, Doctors Hollenbeck, Chojnacki, Davis, and Nadeau.

He then discussed in detail, for the benefit of the new councilors, the general organization and operation of the Society, the role of the councilors and their specific duties. He said that reports from councilors on conditions in their districts would be called for at the annual meeting of the Council in February.

4. Conrad A. Elvehjem

Word had just been received of the death of Doctor Elvehjem, President of the University of Wisconsin, and on motion of Doctors Norby–Van Hecke, carried, Doctor Hill was asked to send a telegram of condolence to his widow.

The suggestion of Doctor Hill that an Elvehjem memorial be established was referred to the Finance Committee, on motion of Doctors Nordby–Houghton, carried, with action taken later in the meeting.

5. Report of Executive Committee

a. Wisconsin's Work Week of Health

The committee presented an illustrative program of a week-long series of conferences which it recommended be held at the Society early in 1963 as an experimental effort to discharge the principal obligations to which the Society is committed through past actions of the House of Delegates on various committee proposals.

Following discussion, the Executive Committee was empowered to implement the program on motion of Doctors Nordby–James, carried.

b. Honorary Membership

On motion of Doctors Mason–Curran, carried, the Council approved the granting of honorary membership to Harold F. Hardman, M. D., Ph. D., chairman of the department of pharmacology at Marquette University and successor to Doctor Beckman as co-editor of Comments on Treatment in the *Wisconsin Medical Journal.*

c. Proposed Communication from Division on Maternal and Child Welfare

On motion of Doctors Willson–Bell, carried, the Council approved, with some modification, a mailing to hospital chiefs of staff by the chairman of this division concerning recommended procedures in the administration of a new oxytocic drug.

Doctor Schulz asked that consideration be given by the appropriate body to the possible utilization for other purposes of available beds specified by the State Board of Health as "maternity only." This was referred to the Division on Maternal and Child Welfare on motion of Doctors Bell–Schulz, carried.

d. Senator Proxmire Correspondence

The Council edited and approved a response to Senator Proxmire's reply to the letter written by Doctor Fox during the Annual Meeting concerning the former's address in Milwaukee on Social Security health care. Doctor Fox's first letter is a matter of record, and to complete that record the balance of their correspondence is hereinafter quoted:

May 31 letter from Senator Proxmire to Doctor Fox:

"I very much appreciate your letter commenting upon my address to the National Federation of State, County and Municipal Employees.

"My reference in the speech that was carried in the *Milwaukee Journal* on May 4 was to people over the age of 65. The latest figures show that over one-half of the people over the age of 65 living alone subsist on a yearly income of $1,000 or less. This means that a widow or widower or an unmarried man or woman in this category has to get by on less than $20 a week.

"Over one-half of all married couples over the age of 65 have an income of less than $2,500 a year. This means that people in this group have a weekly income of less than $50.

"During my trips to the State of Wisconsin I have talked to literally hundreds of people who are desperately ill. These people have told me that they do not have the money to get adequate medical attention. They are much too proud to go to welfare sources or to qualify under the means test set up by the Kerr–Mills Act. Wisconsin is a prosperous state. Other areas are not as blessed as our state. If this situation exists in Wisconsin, I feel sure that it is multiplied many times over in other areas.

"I want to strongly emphasize my deep respect for the medical profession. It has done an outstanding job in handling the problems of the aged. There is much more to be done.

"My father was a doctor. He practiced medicine for more than fifty years in the city of Lake Forest, Illinois. With this kind of background, I would be the last person to take a step which in my judgment would harm the medical profession.

"Warm regards, . . . signed/WILLIAM PROXMIRE, U. S. S."

August 3 letter from Doctor Fox to Senator Proxmire:

"I have taken the opportunity to discuss your reply to my letter of May 7 with a number of physicians, including the members of the Council and officers of the State Medical Society.

"Statistics, as you know, are like Tinker Toys . . . they can be put together in almost any shape. Your use of statistics does not take into account matters of value to the elderly, such as family assistance.

"Now you state you have talked to 'hundreds of people who are desperately ill.' This may be so, but we doubt seriously that they are denying themselves medical attention because of lack of funds. That they need not do so is a well established fact.

"Physicians talk with the seriously ill and chronically ill daily throughout the length and breadth of Wisconsin. We have talked to them about the King–Anderson legislation, about the Kerr–Mills legislation and about voluntary health insurance. We have asked them whether they want to trade the kind of health care they are getting today for health care administered by federal government . . . whether they want to trade the atmosphere in which they now live for one which is supervised and governed by a paternalistic state.

"We find them unwilling to make such an uneven exchange.

"We regret that you did not sense this fact, as did the majority of your colleagues in defeating the Anderson–Javits amendments in the recent Senate vote, but we hope that the medical background of which you are understandably so proud will exert a more enlightening influence on your judgment of such legislation in the future.

Sincerely yours, . . .signed/JAMES C. FOX, M. D."

August 10, 1962, letter from Senator Proxmire to Doctor Fox:

"Thank you for your most recent letter.

"I have no wish to get into an extended debate—as I'm sure you do not—on this issue. I would like to point out one factor in the situation, however, which your letter overlooks. I realize that the medical profession does a marvelously generous and unselfish job of looking after people, without regard to their ability to pay in thousands of cases. The hard fact still remains that many elderly people who *should* have medical attention do not see a doctor because they know they can't afford operations, hospital care, etc. Not a day passes that I don't get at least one letter from an elderly person who is in that category, many of them living on small social security stipends which do not even cover the medicine they need.

"Warm regards, . . . signed/WILLIAM PROXMIRE, U. S. S."

6. Commission on Public Relations and Communications

This Commission had suggested that the Council issue a statement of policy to county medical societies concerning public appearances of physicians on television and radio.

On motion of Doctors Houghton–James, carried, the Council referred the preparation of such a statement back to the Commission, with some suggestions as to its content.

7. Progress Report on Pilot Study of AMA Commission on Cost of Medical Care

A staff report was made by Mr. Reynolds for information only on the status of the pilot study about to be undertaken in Madison on comparative costs of illness.

8. Progress Report on Menominee County Health Survey

Mr. Reynolds reported on preliminary studies and meetings held by the committee authorized during the Annual Meeting.

9. Report of AMA Delegates

Doctor Bernhart, after extending greetings from Dr. J. C. Griffith of Milwaukee, informed the Council of his observations on the June meeting of the AMA House of Delegates, followed by Doctor Galasinski, who served as Chairman of the Reference Committee on Insurance and Medical Service, and comments by Doctor Collentine. General discussion ensued.

10. Secretary's Report on AMA Meeting

Mr. Crownhart reported that during the course of the June meeting, several Wisconsin physicians in attendance expressed their opinion that restatement and re-emphasis of certain positions of the medical profession should result from the AMA meeting, and that he and Doctor Blasingame had appeared together before an informal reference committee session. Doctor Blasingame had subsequently asked that the thoughts expressed by Wisconsin be transmitted to him.

The Council gave general approval to the staff's preparation of an unofficial statement, in conference with the Executive Committee and AMA delegates, for use by the AMA executive office as it sees fit.

11. L. H. Lokvam, M. D.

On motion of Doctor Schulz, variously seconded and carried, the following resolution of the Kenosha County Medical Society was unanimously accepted and incorporated in the record:

"*Resolved*, that in grateful appreciation of the highly commendable service of their colleague, Leif Henry Lokvam, M. D., as president of the State Medical Society of Wisconsin, 1961–1962, having performed his duties with great ability and high statesmanship, thereby adding to the distinction of his high office and bringing credit to his own component society, the Kenosha County Medical Society does herewith contribute $1,000.00 to the State Medical Society Charitable, Educational and Scientific Foundation in his honor.

"*Be it further resolved*, that copies of this resolution be presented to the Council of the State Medical Society and to Doctor Lokvam."

The Council recessed at 5:30 p. m. and reconvened at 1:40 p.m., July 28.

12. Reports of Consultants

a. Donald E. Gill, C.P.A.

Mr. Gill discussed the auditing and advisory functions of his office in relation to the Society and its affiliates, and made a specific suggestion that the Council consider authorizing a statistical study on the costs of operating physicians' offices, which might benefit members of the Society.

Such a study was referred to the Committee on Economic Medicine on motion of Doctors Nordby–Bell, carried.

b. Carl A. Tiffany, Actuary

Mr. Tiffany described his responsibility to review experience of the various contracts and "establish rates in a highly competitive market where you can have some hope of sales and still produce a growing surplus account." He also discussed some possible future areas of activity for Wisconsin Physicians Service.

Following the presentation by Mr. Tiffany and discussion, Doctor Willson introduced two requests from the board of directors of the Medical Society of Milwaukee County:

(1) Whether certain Milwaukee physicians constitute a committee to adjudicate reasonable fees for Milwaukee County physicians under the WPS "no fee schedule" contract.

On motion of Doctors Nordby–Houghton, carried, this was referred to the Commission on Medical Care Plans.

(2) A list of Milwaukee County physicians participating in Wisconsin Physicians Service.

Doctors Houghton–Lokvam amended the second request to the effect that if furnished, Surgical Care also furnish a list of its participating physicians in the state.

On motion of Doctors Bell–Nordby, carried, this also was referred to the Commission on Medical Care Plans.

c. Robert B. Murphy, General Counsel

Mr. Murphy reported to the Council on matters of current interest using the theme, "The Physician and the Law; the Physician in Politics; and the Physician in History."

13. Museum of Medical Progress and Stovall Hall of Health

Mr. Thayer told of improved operations, exhibits, and attendance at the Museum this year, and of plans for the Stovall Hall of Health addition to the complex in Prairie du Chien. He concluded with a suggestion that a special committee of the Council be appointed to plan dedication of the Stovall Hall of Health this fall.

On motion of Doctors Nordby–Kief, carried, this was referred to the Executive Committee of the Foundation.

14. AMA Field Service

Mr. Aubrey Gates, director of this division of the AMA, talked informally to the Council on its activities and the manner in which individual physicians can give assistance.

15. Wisconsin Jaycees and Oral Polio Vaccine

The Council discussed informally with representatives of the state Jaycee organization the latter's project of assisting with mass immunization programs in Wisconsin communities.

On motion of Doctors Nordby–Hollenbeck, carried, the chair appointed a committee consisting of the President, President-elect, and Doctor Houghton to meet further with the Jaycees and work out the details of their participation in immunization programs.

16. Commission on Scientific Medicine

Doctor Farnsworth and Mr. Ragatz reported in detail on activities of this Commission. Doctor Bell, Chairman of the Committee on Scientific Medicine of the Council, reported two recommendations of the Commission requiring Council action:

a. Changing Annual Meeting Schedule

On motion of Doctors Lokvam–Schulz, carried, the Council approved the recommendation that beginning in 1964, and thereafter as it can be arranged, the scientific programs be scheduled on Monday, Tuesday, and Wednesday.

b. Honoraria for Guest Speakers

On motion of Doctors Kief–Schulz, carried, the commission was authorized to provide an honorarium of $50 to guest speakers each day they appear on the program, plus travel expenses.

c. Wisconsin Elks Health Project

Another item reported for information was that a study of alcoholism was under consideration as a project for sponsorship by the Elks.

17. Report on Meeting with State Board of Nursing

Doctor Hill reported on a meeting, also attended by Doctors Egan, Fox, Davis, Gearhart, and Tufts, with representatives of the State Board of Nursing in a continuing attempt to improve liaison and understanding of mutual problems. The major item of discussion was the inspection program being carried on by an investigator for the State Department of Nurses, in which hospitals, physicians' offices and other locations are visited to determine the registration or licensure of persons "holding themselves out" as nurses.

On motion of Doctors Davis–Van Hecke, carried, the Council directed that a bulletin to members and hospital chiefs of staff be sent by the President concerning this matter.

The Council also asked that meetings with the nurses be continued.

18. Podiatry

Mr. Murphy reported a recent Opinion of the Attorney General concluding that the Commissioner of Insurance may require "that a policy form using general terms such as physician or surgeon must definitely include podiatrists, unless it is the intention of the insurer to exclude treatment of feet,

in which case he must state this clearly in the policy." The Opinion also interprets the statutory definition of the practice of podiatry to mean that "a podiatrist is a physician and surgeon for a limited portion of the body."

Although no formal action was taken by the Council, several expressed the strong opinion that immediate exception should be taken to this Opinion, and the staff and legal counsel should continue their efforts under past authority.

19. Commission on Public Policy

Doctor Zach discussed various matters under consideration by this Commission, with particular reference to chiropractic, the Basic Science Law, and a proposed conference on quackery.

Inasmuch as there was not sufficient time for the Council to give full consideration to these matters, on motion of Doctors Nordby–Hollenbeck, carried, the Executive Committee was asked to meet further with Doctor Zach before another meeting of the Commission on Public Policy is held.

20. Executive Session

a. Report of Finance Committee

The Council met in executive session to act on several salary adjustments recommended by the Finance Committee, and also approved the following:

(1) Proration of dues for new members in 1962 should include proration of the special assessment as well.

(2) Doctor Hill's suggestion that Doctor Elvehjem be commemorated through the establishment of a memorial lecture fund in biochemistry or another of the basic sciences, with transfer of $1,000 to the Charitable, Educational and Scientific Foundation for that purpose.

(3) The committee reported receipt of certified audits of all Society activities for its study and later report to the Council.

b. Osteopathy—Report of Planning Committee

Doctor Frank read a proposed statement concerning the relationships of doctors of medicine to doctors of osteopathy. Again due to the lateness of the hour, this was referred to the Executive Committee for report back to the Council.

c. Meeting Next July

If appropriate arrangements can be made, the Council will meet next July in La Crosse and include a trip to Prairie du Chien to see the Museum of Medical Progress and Stovall Hall of Health.

21. Adjournment

The meeting adjourned at 6:20 p. m.

C. H. CROWNHART
Secretary

Approved:

JAMES C. FOX, M. D.
Chairman

Prenatal Facts

SUGGESTED PROCEDURE } **File at hospital in last month of pregnancy. If there are indications of possible premature delivery file earlier. Direct this form to the supervisor of obstetrics of the hospital to which the patient will be admitted.**

Name _____ Address _____ igion _____

Expected date of confinement _____ -- Para_____

Number of abortions_____ miscarriage del._____

multiple birth

Nature

Weig

Speci

Chest

Evaluati

Wasserma

Coombs te

Date of visi

Weight

Heart

FOR YOUR CONVENIENCE, DOCTOR . . .

The Division on Maternal and Child Welfare has prepared a sheet which is recommended for use by all Wisconsin physicians in reference to hospital care of obstetrical patients . . .

You will find this of convenience to you, and of much value to your obstetrical patients. It will alert the hospital to proper care when your patient is admitted for delivery.

Per pad of 100 forms—$2.00.

Write:
DIVISION ON MATERNAL AND CHILD WELFARE
State Medical Society of Wisconsin
Box 1109, Madison 1, Wisconsin

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The

Wisconsin Medical Journal

OWNED and PUBLISHED by the STATE MEDICAL
SOCIETY of WISCONSIN

A Monthly Journal of Medicine and Surgery

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THREE TEACHING PROGRAMS

KENOSHA: Wednesday, Jan. 16, St. Catherine's Hospital
RACINE: Wednesday, Feb. 6, St. Luke's Hospital
GREEN BAY: Tuesday, Feb. 26, St. Vincent's Hospital
ANTIGO: Wednesday, Feb. 27, Langlade County Memorial Hospital

1 MATERNAL MORTALITY INSTITUTE—January 16, St. Catherine's Hospital, Kenosha, 2 to 5 p.m.

UNEXPECTED MASSIVE HEMORRHAGE: *Ben M. Peckham*, M.D., professor and chairman, department of obstetrics and gynecology, University of Wisconsin Medical School

OXYTOCICS—EMPLOYMENT AND SAFEGUARDS: *John R. Evrard*, M.D. assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine

MANAGEMENT OF THE OBESE PREGNANT FEMALE: *George S. Kilkenny*, M.D., associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine

CATASTROPHY OF THE ABRUPTIO PLACENTA: *Frederick J. Hofmeister*, M.D., associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine

Moderator: T. A. Leonard, M.D.
Chairman, Wisconsin Maternal Mortality Study Committee

A.A.G.P. CREDITS: 3 Hours of Category I

ATTENDANCE: Open to all MDs, hospital administrators, OB nurses and other certified hospital personnel. No registration fee, but it will be appreciated if you will indicate your intention to attend.

COOPERATING SPONSORS: Wisconsin State Board of Health and the Charitable, Educational and Scientific Foundation of the State Medical Society.

2 CLINICAL ELECTROCARDIOGRAPHY (An Intensive 5-hour Review)—February 6, St. Luke's Hospital, Racine, 9:30 a.m. to 4 p.m.

INSTRUCTION BY: *Richard H. Wasserburger*, M.D., chief of cardiology, V.A. Hospital, Madison, and associate clinical professor of medicine, University of Wisconsin Medical School.

Instruction will begin promptly at 9:30 a.m. Areas to be covered are: Genesis of the Normal Electrocardiograms; Cardiac Arrhythmias; Common Electrocardiographic Abnormalities; Changes with Pulmonary Emphysema, Anxiety, Mitral Stenosis, etc.; Coronary Heart Disease, and Myocardial Infarction.

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3 SURGERY, INTERNAL MEDICINE, PEDIATRICS—February 26, St. Vincent's Hospital, Green Bay, and February 27, Langlade County Memorial Hospital, Antigo, 1:30 to 5:30 p.m.

NEWER METHODS OF TREATING BURNS: *George E. Collentine*, M.D., assistant clinical professor of surgery, Marquette University School of Medicine

AN APPROACH TO FLUID & ELECTROLYTE PROBLEMS and HYPOTHYROIDISM IN CHILDREN: *Gerald A. Kerrigan*, M.D., associate professor pediatrics, Marquette University School of Medicine

NEW ANTIMICROBIAL DRUGS: *Burton A. Waisbren*, M.D., assistant clinical professor of medicine, Marquette University School of Medicine

OVERWHELMING SEPSIS: *Burton A. Waisbren*, M.D. and *George E. Collentine*, M.D.

A.A.G.P. CREDITS: 3 Hours of Category I

ATTENDANCE: While no fee is required, advance registration will be appreciated for the preparation of badges and local arrangements.

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References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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(1) Danowski, T. S.: Diabetes Mellitus, Baltimore, Williams & Wilkins, 1957, p. 239. (2) McCune, W. G.: M. Clin. North America 44:1479, 1960. (3) Ackerman, R. F., et al.: Diabetes 7:398, 1958.

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This is a reminder advertisement. For adequate information for use, please consult manufacturer's literature. Eli Lilly and Company, Indianapolis 6, Indiana. 240120

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when urinary tract infections present a therapeutic challenge...

CHLOROMYCETIN®

(chloramphenicol, Parke-Davis)

Often recurrent...often resistant to treatment, urinary tract infections are among the most frequent and troublesome types of infections seen in clinical practice.[1,2] In such infections, successful therapy is usually dependent on identification and susceptibility testing of invading organisms, administration of appropriate antibacterial agents, and correction of obstruction or other underlying pathology.

Of these agents, one author reports: "Chloramphenicol still has the widest and most effective activity range against infections of the urinary tract. It is particularly useful against the coliform group, certain Proteus species, the micrococci and the enterococci."[1] CHLOROMYCETIN is of particular value in the management of urinary tract infections caused by *Escherichia coli* and *Aerobacter aerogenes*.[3] In addition to these clinical findings, the wide antibacterial range of CHLOROMYCETIN continues to be confirmed by recent *in vitro* studies.[4-6]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100. See package insert for details of administration and dosage.

Warning: Serious and even fatal blood dyscrasias (aplastic anemia, hypoplastic anemia, thrombocytopenia, granulocytopenia) are known to occur after the administration of chloramphenicol. Blood dyscrasias have occurred after both short-term and prolonged therapy with this drug. Bearing in mind the possibility that such reactions may occur, chloramphenicol should be used only for serious infections caused by organisms which are susceptible to its antibacterial effects. Chloramphenicol should not be used when other less potentially dangerous agents will be effective, or in the treatment of trivial infections, such as colds, influenza, or viral infections of the throat, or as a prophylactic agent. *Precautions:* It is essential that adequate blood studies be made during treatment with the drug. While blood studies may detect early peripheral blood changes, such as leukopenia or granulocytopenia, before they become irreversible, such studies cannot be relied upon to detect bone marrow depression prior to development of aplastic anemia.

References: (1) Malone, F. J., Jr.: *Mil. Med.* **125**:836, 1960. (2) Martin, W. J.; Nichols, D. R., & Cook, E. N.: *Proc. Staff Meet. Mayo Clin.* **34**:187, 1959. (3) Ullman, A.: *Delaware M. J.* **32**:97, 1960. (4) Petersdorf, R. G.; Hook, E. W.; Curtin, J. A., & Grossberg, S. E.: *Bull. Johns Hopkins Hosp.* **108**:48, 1961. (5) Jolliff, C. R.; Engelhard, W. E.; Ohlsen, J. R.; Heidrick, P. J., & Cain, J. A.: *Antibiotics & Chemother.* **10**: 694, 1960. (6) Lind, H. E.: *Am. J. Proctol.* **11**:392, 1960.

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